# EXHIBIT 31

# Summary Plan Description

## Lockton, Inc.
## Choice Plus with HSA Plan

Effective: January 1, 2015
Group Number: 700698

UnitedHealthcare®
Healing health care. Together.®

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## SECTION 1 - WELCOME

**Quick Reference Box**

- Member services, claim inquiries, Personal Health Support and Mental Health/Substance Use Disorder Administrator: (800) 873-9573;
- Claims submittal address: UnitedHealthcare - Claims, P.O. Box 30555, Salt Lake City, Utah 84130-0555; and
- Online assistance: **www.myuhc.com**.

Lockton, Inc. is pleased to provide you with this Summary Plan Description (SPD), which describes the health Benefits available to you and your covered family members under the group medical program component of the Lockton, Inc. Welfare Benefit Plan. The Lockton, Inc. Welfare Benefit Plan is a single plan that wraps together various welfare benefit programs for purposes of the Employee Retirement Income Security Act of 1994, as amended ("ERISA"). This group medical program component of the Lockton, Inc. Welfare Benefit Plan is referred to herein as the "Plan." This SPD includes summaries of:

- who is eligible;
- services that are covered, called Covered Health Services;
- services that are not covered, called Exclusions;
- how Benefits are paid; and
- your rights and responsibilities under the Plan.

This SPD is designed to meet your information needs and the disclosure requirements of the Employee Retirement Income Security Act of 1974 (ERISA). It supersedes any previous printed or electronic SPD for this Plan.

Lockton, Inc. intends to continue this Plan indefinitely, but reserves the right, in its sole discretion, to modify, change, revise, amend or terminate the Plan at any time, for any reason, and without prior notice. This SPD is not to be construed as a contract of or for employment. If there should be an inconsistency between the contents of this summary and the contents of the full plan document for the Plan, your rights shall be determined under the full plan document and not under this summary.

UnitedHealthcare is a private healthcare claims administrator. UnitedHealthcare's goal is to give you the tools you need to make wise healthcare decisions. UnitedHealthcare also helps your employer to administer claims. Although UnitedHealthcare will assist you in many ways, it does not guarantee any Benefits. Lockton, Inc. is solely responsible for paying Benefits described in this SPD.

Please read this SPD thoroughly to learn how the Plan works. If you have questions contact your local Human Resources department or call the number on the back of your ID card.

**How To Use This SPD**

- Read the entire SPD, and share it with your family. Then keep it in a safe place for future reference.
- Many of the sections of this SPD are related to other sections. You may not have all the information you need by reading just one section.
- You can find copies of your SPD and any future amendments by contacting Human Resources.
- Capitalized words in the SPD have special meanings and are defined in Section 14, *Glossary*.
- If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in Section 14, *Glossary*.
- Lockton, Inc. is also referred to as the Company.
- If there is a conflict between this SPD and any benefit summaries (other than Summaries of Material Modifications) provided to you, this SPD will control.

# SECTION 2 - INTRODUCTION

**What this section includes:**

- Who's eligible for coverage under the Plan;
- The factors that impact your cost for coverage;
- Instructions and timeframes for enrolling yourself and your eligible Dependents;
- When coverage begins; and
- When you can make coverage changes under the Plan.

## Eligibility

You are eligible to enroll in the Plan if you are a regular full-time or part-time Participant who work on average at least 25 hours per week. Depending on your status, your eligibility is as follows:

- If you are a Participant who is employed an average of at least 37.5 hours or more per week, you can enroll yourself and any of your eligible Dependents (as defined below);
- If you are a Participant who is employed an average of at least 30 hours per week, you can enroll yourself and your eligible Dependent children (as defined below);
- If you are a Participant who is employed an average of least 25 hours per week, you can enroll yourself but your Dependents are not eligible to participate.

If it is reasonably expected as of your first day of work that you will satisfy one of the above requirements, you will be eligible to enroll as of your date of hire. Additional rules, which are set forth in Addendum B, *Additional Eligibility Rules*, will determine your (and your Dependents) continued eligibility to participate in the Plan.

If you are a seasonal, part-time, or variable hour employee and it is not reasonably expected as of your first day of work that you will be employed on average at least 30 hours of service per week (or 25 hours for employee-only coverage), there are special rules that may determine if you (and your Dependents) will become eligible to participate in the Plan at a later date. Those rules are also set forth in Addendum B, *Additional Eligibility Rules*.

An eligible Dependent is considered to be:

- your Spouse, as defined in Section 14, *Glossary*;
- your Domestic Partner, as defined in Section 14, *Glossary;*
- your or your Spouse's or Domestic Partner's married or unmarried child who is under age 26, including a natural child, stepchild, a legally adopted child, a child placed for adoption or a child for whom you or your Spouse are the legal guardian;
- an unmarried child age 26 or over who is or becomes disabled and who is dependent upon you.

***Note:*** Your Dependents may not enroll in the Plan unless you are also enrolled. If you and your Spouse or Domestic Partner are both covered under the Plan, you may each be enrolled as a Participant or be covered as a Dependent of the other person, but not both. In addition, if you and your Spouse or Domestic Partner are both covered under the Plan, only one parent may enroll your child as a Dependent.

A Dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order, as described in Section 13, *Other Important Information*.

## Retiree Eligibility

A retired Participant may, pursuant to the rules of this subsection, continue his or her coverage under the Plan (as well as the coverage of his or her eligible Dependents) after termination of employment, but only if the conditions of this subsection are satisfied. In order to continue coverage, a retired Participant must satisfy the "rule of 75," which means that the sum of the retired Participant's age plus his or her years of service with the Employer must equal or exceed 75. For purposes of determining whether the "rule of 75" is satisfied, the term "years of Service with the Employer" in the preceding sentence shall include an individual's years of service with JTL Consulting, LLC and/or JTL Consulting of Texas, LLLP, notwithstanding that JTL Consulting, LLC and/or JTL Consulting of Texas, LLLP may not have been within the Plan Sponsor's control group under Sections 414(b), (c) and (m) of the Tax Code (as such Sections may be amended from time to time) at the time such years of service were performed.

If coverage is obtained pursuant to this subsection (whether as a retired Participant or as an eligible Dependent of a retired Participant), that coverage will terminate upon the occurrence of the earlier of the following: (i) as of the date the retired Participant becomes eligible for Medicare coverage; or (ii) as soon as the retired Participant becomes eligible for other group health coverage through a subsequent employer.

To continue coverage under this subsection, a retired Participant must make contributions on behalf of himself or herself and his or her eligible Dependents, and must apply for the retiree coverage within the timeframe and in the manner determined by the Employer. The amount and timing of the contributions will be determined from time to time by the Employer.

## Cost of Coverage

You and Lockton, Inc. share in the cost of the Plan. Your contribution amount depends on the family members you choose to enroll.

Your contributions are deducted from your paychecks on a before-tax basis. Before-tax dollars come out of your pay before federal income and Social Security taxes are withheld - and in most states, before state and local taxes are withheld. This gives your contributions a special tax advantage and lowers the actual cost to you.

Your contributions are subject to review and Lockton, Inc. reserves the right to change your contribution amount from time to time.

You can obtain current contribution rates by calling Human Resources.

## How to Enroll

To enroll, call Human Resources within 31 days of the date you first become eligible for medical Plan coverage. If you do not enroll within 31 days, you will need to wait until the next annual Open Enrollment to make your benefit elections.

Each year during annual Open Enrollment, you have the opportunity to review and change your medical election. Any changes you make during Open Enrollment will become effective the following January 1.

**Important**
If you wish to change your benefit elections following your marriage, birth, adoption of a child, placement for adoption of a child or other family status change, you must contact Human Resources within 31 days of the event. Otherwise, you will need to wait until the next annual Open Enrollment to change your elections.

## When Coverage Begins

Once Human Resources receives your properly completed enrollment, coverage will begin on your date of hire, or the applicable date under Addendum B in the case of a seasonal, part-time, or variable hour employee governed by that Addendum. Coverage for your Dependents will start on the date your coverage begins, provided you have enrolled them in a timely manner.

Coverage for a Spouse or Dependent stepchild that you acquire via marriage becomes effective the date of your marriage, provided you notify Human Resources within 31 days of your marriage. Coverage for Dependent children acquired through birth, adoption, or placement for adoption is effective the date of the family status change, provided you notify Human Resources within 31 days of the birth, adoption, or placement.

### *If You Are Hospitalized When Your Coverage Begins*

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, the Plan will pay Benefits for Covered Health Services related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Plan.

You should notify UnitedHealthcare within 48 hours of the day your coverage begins, or as soon as is reasonably possible.

## Changing Your Coverage

You may make coverage changes during the year only if you experience a change in family status. The change in coverage must be consistent with the change in status (e.g., you cover your Spouse following your marriage, your child following an adoption, etc.). The following are considered family status changes for purposes of the Plan:

- loss of eligibility for coverage as a result of certain events including (but not limited to) legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment, and any

loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;

- your marriage, or the birth, adoption, placement for adoption or legal guardianship of a child;
- a change in your Spouse's (or Domestic Partner's) employment or involuntary loss of health coverage (other than coverage under the Medicare or Medicaid programs) under another employer's plan;
- exhaustion of COBRA continuation coverage;
- the death of a Dependent;
- your Dependent child no longer qualifying as an eligible Dependent;
- a change in your or your Spouse's (or Domestic Partner's) position or work schedule that impacts eligibility for health coverage;
- coverage was non-COBRA coverage and employer contributions toward the coverage terminate (this applies even if you or your eligible Dependent continues to receive coverage under the non-COBRA coverage by paying the amounts previously paid by the employer);
- you or your eligible Dependent were enrolled in an HMO (or other arrangement) and experienced a loss of coverage because you or your eligible Dependent no longer resides, lives or works in that HMO's (or other arrangement's) service area, whether or not within the choice of you or your eligible Dependent (and, in the case of coverage in the group market, no other benefit package is available to you or your eligible Dependent);
- a situation in which a plan no longer offers any benefits to a class of similarly-situated individuals that include you or your eligible Dependent;
- termination of your or your Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage as a result of loss of eligibility (you must contact Human Resources within 60 days of termination);
- you or your Dependent become eligible for a premium assistance subsidy under Medicaid or CHIP (you must contact Human Resources within 60 days of determination of subsidy eligibility);
- a strike or lockout involving you or your Spouse (or Domestic Partner); or
- a court or administrative order.

Unless otherwise noted above, if you wish to change your elections, you must contact Human Resources within 31 days of the change in family status. Otherwise, you will need to wait until the next annual Open Enrollment.

While some of these changes in status are similar to qualifying events under COBRA, you, or your eligible Dependent, do not need to elect COBRA continuation coverage to take advantage of the special enrollment rights listed above. These generally will also be available to you or your eligible Dependent if COBRA is elected.

***Note:*** Any child under age 26 who is placed with you for adoption will be eligible for coverage on the date the child is placed with you, even if the legal adoption is not yet final. If you do not legally adopt the child, all medical Plan coverage for the child will end when your legal obligation relating to the placement ends. No provision will be made for continuing coverage (such as COBRA coverage) for the child.

***Change in Family Status - Example***
Jane is married and has two children who qualify as Dependents. At annual Open Enrollment, she elects not to participate in Lockton, Inc.'s medical plan, because her husband, Tom, has family coverage under his employer's medical plan. In June, Tom loses his job as part of a downsizing. As a result, Tom loses his eligibility for medical coverage. Due to this family status change, Jane can elect family medical coverage under Lockton, Inc.'s medical plan outside of annual Open Enrollment.

# SECTION 3 - HOW THE PLAN WORKS

**What this section includes:**

- Accessing Benefits;
- Eligible Expenses;
- Annual Deductible;
- Coinsurance; and
- Out-of-Pocket Maximum.

## Accessing Benefits

As a participant in this Plan, you have the freedom to choose the Physician or health care professional you prefer each time you need to receive Covered Health Services. The choices you make affect the amounts you pay, as well as the level of Benefits you receive and any benefit limitations that may apply.

You are eligible for the Network level of Benefits under this Plan when you receive Covered Health Services from Physicians and other health care professionals who have contracted with UnitedHealthcare to provide those services.

You can choose to receive Network Benefits or Non-Network Benefits.

**Network Benefits** apply to Covered Health Services that are provided by a Network Physician or other Network provider.

**Non-Network Benefits** apply to Covered Health Services that are provided by a non-Network Physician or other non-Network provider, or Covered Health Services that are provided at a non-Network facility.

Depending on the geographic area and the service you receive, you may have access through our Shared Savings Program to non-Network providers who have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from these providers, the Coinsurance will remain the same as it is when you receive Covered Health Services from non-Network providers who have not agreed to discount their charges; however, the total that you owe may be less when you receive Covered Health Services from Shared Savings Program providers than from other non-Network providers because the Eligible Expense may be a lesser amount.

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under the Plan. As a result, they may bill you for the entire cost of the services you receive.

Generally, when you receive Covered Health Services from a Network provider, you pay less than you would if you receive the same care from a non-Network provider. Therefore, in most instances, your out-of-pocket expenses will be less if you use a Network provider.

If you choose to seek care outside the Network, the Plan generally pays Benefits at a lower level. You are required to pay the amount that exceeds the Eligible Expense. The amount in excess of the Eligible Expense could be significant, and this amount does not apply to the Out-of-Pocket Maximum. You may want to ask the non-Network provider about their billed charges before you receive care. Emergency services received at a non-Network Hospital are covered at the Network level.

***Health Services from Non-Network Providers Paid as Network Benefits***

If specific Covered Health Services are not available from a Network provider, you may be eligible to receive Network Benefits when Covered Health Services are received from a non-Network provider. In this situation, your Network Physician will notify UnitedHealthcare, and if UnitedHealthcare confirms that care is not available from a Network provider, UnitedHealthcare will work with you and your Network Physician to coordinate care through a non-Network provider.

**Looking for a Network Provider?**
In addition to other helpful information, **www.myuhc.com**, UnitedHealthcare's consumer website, contains a directory of health care professionals and facilities in UnitedHealthcare's Network. While Network status may change from time to time, **www.myuhc.com** has the most current source of Network information. Use **www.myuhc.com** to search for Physicians available in your Plan.

***Network Providers***

UnitedHealthcare or its affiliates arrange for health care providers to participate in a Network. At your request, UnitedHealthcare will send you a directory of Network providers free of charge. Keep in mind, a provider's Network status may change. To verify a provider's status or request a provider directory, you can call UnitedHealthcare at the toll-free number on your ID card or log onto **www.myuhc.com**.

Network providers are independent practitioners and are not employees of Lockton, Inc. or UnitedHealthcare.

UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling UnitedHealthcare. A directory of providers is available online at **www.myuhc.com** or by calling the number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition

period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact UnitedHealthcare at the number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with UnitedHealthcare to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact UnitedHealthcare for assistance.

### *Designated Facilities and Other Providers*

If you have a medical condition that UnitedHealthcare believes needs special services, UnitedHealthcare may direct you to a Designated Facility or Designated Physician chosen by UnitedHealthcare. If you require certain complex Covered Health Services for which expertise is limited, UnitedHealthcare may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, UnitedHealthcare may reimburse certain travel expenses at UnitedHealthcare's discretion.

In both cases, Network Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider chosen by UnitedHealthcare.

### *Limitations on Selection of Providers*

If UnitedHealthcare determines that you are using health care services in a harmful or abusive manner, you may be required to select a Network Physician to provide and coordinate all of your future Covered Health Services. If you don't make a selection within 31 days of the date you are notified, UnitedHealthcare will select a single Network Physician for you. In the event that you do not use the selected Network Physician Covered Health Services will be paid as Non-Network Benefits.

## Eligible Expenses

Lockton, Inc. has delegated to UnitedHealthcare the initial discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.

Eligible Expenses are the amount UnitedHealthcare determines that UnitedHealthcare will pay for Benefits. For Network Benefits, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Non-Network Benefits for Covered Health Services provided by a non-Network provider (other than Emergency Health Services or services otherwise arranged by UnitedHealthcare), you will be responsible to the non-Network Physician or provider for any amount billed that is greater than the amount UnitedHealthcare determines to be an Eligible Expense as described below.

For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount UnitedHealthcare will pay for Eligible Expenses. Eligible Expenses are determined solely in

accordance with UnitedHealthcare's reimbursement policy guidelines, as described in the SPD.

**For Network Benefits**, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are UnitedHealthcare's contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by UnitedHealthcare, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

**For Non-Network Benefits**, Eligible Expenses are based on either of the following:

- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on:
  - Negotiated rates agreed to by the non-Network provider and either UnitedHealthcare or one of UnitedHealthcare's vendors, affiliates or subcontractors, at UnitedHealthcare's discretion.
  - If rates have not been negotiated, then one of the following amounts:
    - For Covered Health Services other than Pharmaceutical Products, Eligible Expenses are determined based on available data resources of competitive fees in that geographic area.
    - For Mental Health Services and Substance Use Disorder Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.
    - When Covered Health Services are Pharmaceutical Products, Eligible Expenses are determined based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market.
    - When a rate is not published by *CMS* for the service, UnitedHealthcare uses a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, UnitedHealthcare will use a comparable scale(s). UnitedHealthcare and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to UnitedHealthcare's website at **www.myuhc.com** for information regarding the vendor that provides the applicable gap fill relative value scale information.

**IMPORTANT NOTICE**: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

**Don't Forget Your ID Card**
Remember to show your UnitedHealthcare ID card every time you receive health care services from a provider. If you do not show your ID card, a provider has no way of knowing that you are enrolled under the Plan.

## Annual Deductible

The Annual Deductible is the amount of Eligible Expenses you must pay each calendar year for Covered Health Services before you are eligible to begin receiving Benefits. There are separate Network and non-Network Annual Deductibles for this Plan. The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year.

The Annual Deductible applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 15, *Outpatient Prescription Drugs*.

Eligible Expenses charged by both Network and non-Network providers apply towards both the Network individual and family Deductibles and the non-Network individual and family Deductibles.

Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum benefit limit. As a result, the limited benefit will be reduced by the number of days or visits you used toward meeting the Annual Deductible.

## Coinsurance

Coinsurance is the percentage of Eligible Expenses that you are responsible for paying. Coinsurance is a fixed percentage that applies to certain Covered Health Services after you meet the Annual Deductible.

**Coinsurance – Example**
Let's assume that you receive Plan Benefits for outpatient surgery from a Network provider. Since the Plan pays 80% after you meet the Annual Deductible, you are responsible for paying the other 20%. This 20% is your Coinsurance.

## Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum is the most you pay each calendar year for Covered Health Services. There are separate Network and non-Network Out-of-Pocket Maximums for this Plan. If your eligible out-of-pocket expenses in a calendar year exceed the annual maximum, the Plan pays 100% of Eligible Expenses for Covered Health Services through the end of the calendar year.

The Out-of-Pocket Maximum applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 15, *Outpatient Prescription Drugs*.

Eligible Expenses charged by both Network and non-Network providers apply toward both the Network individual and family Out-of-Pocket Maximums and the non-Network individual and family Out-of-Pocket Maximums.

The following table identifies what does and does not apply toward your Network and non-Network Out-of-Pocket Maximums:

| Plan Features | Applies to the Network Out-of-Pocket Maximum? | Applies to the Non-Network Out-of-Pocket Maximum? |
|---|---|---|
| Payments toward the Annual Deductible | Yes | Yes |
| Coinsurance Payments even those for Covered Health Services available in Section 15, *Outpatient Prescription Drugs* | Yes | Yes |
| Charges for non-Covered Health Services | No | No |
| The amounts of any reductions in Benefits you incur by not notifying Personal Health Support | No | No |
| Charges that exceed Eligible Expenses | No | No |

## SECTION 4 - PERSONAL HEALTH SUPPORT

**What this section includes:**

- An overview of the Personal Health Support program; and
- Covered Health Services for which you need to contact the Claims Administrator or Personal Health Support.

UnitedHealthcare provides a program called Personal Health Support designed to encourage personalized, efficient care for you and your covered Dependents.

Personal Health Support Nurses center their efforts on prevention, education, and closing any gaps in your care. The goal of the program is to ensure you receive the most appropriate and cost-effective services available. A Personal Health Support Nurse is notified when you or your provider calls the toll-free number on your ID card regarding an upcoming treatment or service.

If you are living with a chronic condition or dealing with complex health care needs, UnitedHealthcare may assign to you a primary nurse, referred to as a Personal Health Support Nurse to guide you through your treatment. This assigned nurse will answer questions, explain options, identify your needs, and may refer you to specialized care programs. The Personal Health Support Nurse will provide you with their telephone number so you can call them with questions about your conditions, or your overall health and well-being.

Personal Health Support Nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components are subject to change without notice. As of the publication of this SPD, the Personal Health Support program includes:

- **Admission counseling** - For upcoming inpatient Hospital admissions for certain conditions, a Treatment Decision Support Nurse may call you to help answer your questions and to make sure you have the information and support you need for a successful recovery.
- **Inpatient care management** - If you are hospitalized, a nurse will work with your Physician to make sure you are getting the care you need and that your Physician's treatment plan is being carried out effectively.
- **Readmission Management** - This program serves as a bridge between the Hospital and your home if you are at high risk of being readmitted. After leaving the Hospital, if you have a certain chronic or complex condition, you may receive a phone call from a Personal Health Support Nurse to confirm that medications, needed equipment, or follow-up services are in place. The Personal Health Support Nurse will also share important health care information, reiterate and reinforce discharge instructions, and support a safe transition home.

- **Risk Management** - Designed for participants with certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies. Participants may receive a phone call from a Personal Health Support Nurse to discuss and share important health care information related to the participant's specific chronic or complex condition.

If you do not receive a call from a Personal Health Support Nurse but feel you could benefit from any of these programs, please call the toll-free number on your ID card.

## Requirements for Notifying the Claims Administrator or Personal Health Support

Network providers are generally responsible for notifying the Claims Administrator or Personal Health Support before they provide certain services to you. However, there are some Network Benefits for which you are responsible for notifying the Claims Administrator or Personal Health Support.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for notifying the Claims Administrator or Personal Health Support before you receive these Covered Health Services. In many cases, your Non-Network Benefits will be reduced if the Claims Administrator or Personal Health Support is not notified.

The services that require notification are:

- ambulance – non-emergent air;
- Clinical Trials;
- Congenital heart disease surgeries;
- dental services - accident only;
- dental services – anesthesia and hospitalization;
- Durable Medical Equipment for items that will cost more than $1,000 to purchase or rent, including diabetes equipment for the management and treatment of diabetes;
- home health care;
- hospice care - inpatient;
- Hospital Inpatient Stay- all scheduled admissions and maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery;
- manipulative treatment as described under Rehabilitation Services - Outpatient Therapy and Manipulative Treatment in Section 6, Additional Coverage Details;
- maternity care that exceeds the delivery timeframes as described in Section 6, *Additional Coverage Details*;
- outpatient dialysis treatments as described in under *Therapeutic Treatments - Outpatient* in Section 6, *Additional Coverage Details*;

- Reconstructive Procedures, including breast reconstruction surgery following mastectomy and breast reduction surgery;
- Skilled Nursing Facility/Inpatient Rehabilitation Facility Services;
- Substance Use Disorder Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); and
- transplants.

Notification is required within two business days of admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital as a result of an Emergency.

For notification timeframes, and any reductions in Benefits that apply if you do not notify the Claims Administrator or contact Personal Health Support, see Section 6, *Additional Coverage Details*.

### Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before the Plan pays Benefits) the notification requirements do not apply to you. Since Medicare is the primary payer, the Plan will pay as secondary payer as described in Section 10, *Coordination of Benefits (COB)*. You are not required to provide notification before receiving Covered Health Services.

# SECTION 5 - PLAN HIGHLIGHTS

**What this section includes:**
- Payment Terms and Features.
- Schedule of Benefits.

## Payment Terms and Features

The table below provides an overview of the Plan's Annual Deductible and Out-of-Pocket Maximum.

| Plan Features | Network Amounts | Non-Network Amounts |
|---|---|---|
| **Annual Deductible** | | |
| ■ Individual | $1,300 | $2,600 |
| ■ Family (cumulative Annual Deductible) | $2,600 | $5,200 |
| The Plan does not require that you or a covered Dependent meet the individual Deductible in order to satisfy the family Deductible. If more than one person in a family is covered under the Plan, the individual coverage Deductible stated in this table above does not apply. Instead, the family Deductible applies and no one in the family is eligible to receive Benefits until the family Deductible is satisfied.<br><br>The Annual Deductible applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 15, *Outpatient Prescription Drugs*. | | |
| **Annual Out-of-Pocket Maximum** | | |
| ■ Individual | $2,600 | $5,200 |
| ■ Family (cumulative Out-of-Pocket Maximum) | $5,200 | $10,400 |

| Plan Features | Network Amounts | Non-Network Amounts |
|---|---|---|
| The Plan does not require that you or a covered Dependent meet the individual Out-of-Pocket Maximum in order to satisfy the family Out-of Pocket Maximum. If more than one person in a family is covered under the Plan, the individual coverage Out-of-Pocket Maximum stated in this table above does not apply. Instead, for family coverage the family Out-of-Pocket Maximum applies.<br><br>The Annual Deductible applies toward the Out-of-Pocket Maximum for all Covered Health Services.<br><br>The Annual Out-of-Pocket Maximum applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 15, *Outpatient Prescription Drugs*. | | |
| **Lifetime Maximum Benefit**<br><br>There is no dollar limit to the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan.<br><br>Generally the following are considered to be essential benefits under the *Patient Protection and Affordable Care Act*:<br><br>Ambulatory patient services; emergency services, hospitalization; maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment); prescription drug products; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. | Unlimited | |

This table provides an overview of the Plan's coverage levels. For detailed descriptions of your Benefits, refer to Section 6, *Additional Coverage Details*.

| Covered Health Services[1] | Percentage of Eligible Expenses Payable by the Plan: | |
|---|---|---|
| | **Network** | **Non-Network** |
| **Ambulance Services** | | |
| ■ Emergency Ambulance | 80% after you meet the Annual Deductible | 80% after you meet the Network Annual Deductible |
| ■ Non-Emergency Ambulance | 80% after you meet the Annual Deductible | 80% after you meet the Network Annual Deductible |
| **Cancer Resource Services (CRS)[2]** ■ Hospital Inpatient Stay | 80% after you meet the Annual Deductible | 60% after you meet the Annual Deductible |
| **Clinical Trials** Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Non-Network Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.) | Depending upon where the Covered Health Service is provided, Benefits for Clinical Trials will be the same as those stated under each Covered Health Service category in this section. | |
| **Congenital Heart Disease (CHD) Surgeries** Network and Non-Network Benefits under this section include only the inpatient facility charges for the congenital heart disease (CHD) surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Service category in this section. | 80% after you meet the Annual Deductible | 60% after you meet the Annual Deductible |

| Covered Health Services[1] | Percentage of Eligible Expenses Payable by the Plan: | |
|---|---|---|
| | **Network** | **Non-Network** |
| **Dental Services - Accident Only** | 80% after you meet the Annual Deductible | 80% after you meet the Network Annual Deductible |
| **Dental Services – Anesthesia and Hospitalization** | 80% after you meet the Annual Deductible | 60% after you meet the Annual Deductible |
| **Diabetes Services**<br>Diabetes Self-Management and Training/ Diabetic Eye Examinations/Foot Care | Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be paid the same as those stated under each Covered Health Service category in this section. | |
| ■ Diabetes Self-Management Items | Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* in this section and in Section 15, *Prescription Drugs*. | |
| **Durable Medical Equipment (DME)** | 80% after you meet the Annual Deductible | 60% after you meet the Annual Deductible |
| **Emergency Health Services - Outpatient** | 80% after you meet the Annual Deductible | 80% after you meet the Network Annual Deductible |
| **Hearing Aids**<br>See Section 6, *Additional Coverage Details*, for limits | 80% after you meet the Annual Deductible | 60% after you meet the Annual Deductible |
| **Hearing Testing** | 80% after you meet the Annual Deductible | 60% after you meet the Annual Deductible |
| **Home Health Care**<br>See Section 6, *Additional Coverage Details*, for visit limits | 80% after you meet the Annual Deductible | 60% after you meet the Annual Deductible |

| Covered Health Services[1] | Percentage of Eligible Expenses Payable by the Plan: | |
|---|---|---|
| | Network | Non-Network |
| **Hospice Care** | 80% after you meet the Annual Deductible | 60% after you meet the Annual Deductible |
| **Hospital - Inpatient Stay** | 80% after you meet the Annual Deductible | 60% after you meet the Annual Deductible |
| **Lab, X-Ray and Diagnostics - Outpatient** | 80% after you meet the Annual Deductible | 60% after you meet the Annual Deductible |
| **Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient** | 80% after you meet the Annual Deductible | 60% after you meet the Annual Deductible |
| **Mental Health Services** | 80% after you meet the Annual Deductible | 60% after you meet the Annual Deductible |
| **Nutritional Counseling** | 80% after you meet the Annual Deductible | 60% after you meet the Annual Deductible |
| **Ostomy Supplies** | 80% after you meet the Annual Deductible | 60% after you meet the Annual Deductible |
| **Pharmaceutical Products - Outpatient** | 80% after you meet the Annual Deductible | 60% after you meet the Annual Deductible |
| **Physician Fees for Surgical and Medical Services** | 80% after you meet the Annual Deductible | 60% after you meet the Annual Deductible |
| **Physician's Office Services - Sickness and Injury** | 80% after you meet the Annual Deductible | 60% after you meet the Annual Deductible |
| **Pregnancy – Maternity Services**<br>A Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. | Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section. | |

| Covered Health Services[1] | Percentage of Eligible Expenses Payable by the Plan: | |
|---|---|---|
| | Network | Non-Network |
| **Preventive Care Services**<br>■ Physician Office Services | 100% | 60% after you meet the Annual Deductible |
| ■ Lab, X-ray or Other Preventive Test | 100% | 60% after you meet the Annual Deductible |
| ■ Breast Pumps | 100% | 60% after you meet the Annual Deductible |
| See Section 6, *Additional Coverage Details*, for Benefit details | | |
| In the event Preventive Care Services are not available from a Network Provider they will be covered at 100% from a Non-Network Provider. | | |
| **Private Duty Nursing - Outpatient** | 80% after you meet the Annual Deductible | 60% after you meet the Annual Deductible |
| **Prosthetic Devices** | 80% after you meet the Annual Deductible | 60% after you meet the Annual Deductible |
| **Reconstructive Procedures** | 80% after you meet the Annual Deductible | 60% after you meet the Annual Deductible |
| **Reconstructive Procedures** | Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section. | |
| **Rehabilitation Services - Outpatient Therapy and Manipulative Treatment**<br>See Section 6, *Additional Coverage Details*, for Benefit limits | 80% after you meet the Annual Deductible | 60% after you meet the Annual Deductible |
| **Scopic Procedures - Outpatient Diagnostic and Therapeutic** | 80% after you meet the Annual Deductible | 60% after you meet the Annual Deductible |

| Covered Health Services[1] | Percentage of Eligible Expenses Payable by the Plan: | |
|---|---|---|
| | Network | Non-Network |
| **Skilled Nursing Facility/Inpatient Rehabilitation Facility Services** | 80% after you meet the Annual Deductible | 60% after you meet the Annual Deductible |
| **Substance Use Disorder Services** | 80% after you meet the Annual Deductible | 60% after you meet the Annual Deductible |
| **Surgery – Outpatient** | 80% after you meet the Annual Deductible | 60% after you meet the Annual Deductible |
| **Therapeutic Treatments - Outpatient** | 80% after you meet the Annual Deductible | 60% after you meet the Annual Deductible |
| **Transplantation Services**<br>See Section 6, *Additional Coverage Details*, for Benefit limits | 80% after you meet the Annual Deductible | 60% after you meet the Annual Deductible |
| **Travel and Lodging**<br>(Covered Health Services must be received at a Designated Facility)<br>See Section 6, *Additional Coverage Details*, for Benefit limits | For patient and companion(s) of patient undergoing cancer, Congenital Heart Disease treatment or transplant procedures | |
| **Urgent Care Center Services** | 80% after you meet the Annual Deductible | 60% after you meet the Annual Deductible |
| **Vision Examinations**<br>See Section 6, *Additional Coverage Details*, for visit limits | 80% after you meet the Annual Deductible | 60% after you meet the Annual Deductible |

[1]In general, your Network provider must notify the Claims Administrator or Personal Health Support, as described in Section 4, *Personal Health Support* before you receive certain Covered Health Services. There are some Network Benefits, however, for which you should notify the Claims Administrator or Personal Health Support. See Section 6, *Additional Coverage Details* for further information.

[2]These Benefits are for Covered Health Services provided through CRS at a Designated Facility. For oncology services not provided through CRS, the Plan pays Benefits as described under *Physician's Office Services - Sickness and Injury*, *Physician Fees for Surgical and Medical Services*, *Hospital - Inpatient Stay*, *Surgery - Outpatient*, *Scopic Procedures - Outpatient Diagnostic and Therapeutic* Lab, *X-Ray and Diagnostics – Outpatient*, and *Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine – Outpatient*.

# SECTION 6 - ADDITIONAL COVERAGE DETAILS

**What this section includes:**

- Covered Health Services for which the Plan pays Benefits; and
- Covered Health Services that require you to notify the Claims Administrator or Personal Health Support before you receive them, and any reduction in Benefits that may apply if you do not call the Claims Administrator or Personal Health Support.

This section supplements the second table in Section 5, *Plan Highlights*.

While the table provides you with Benefit limitations along with Coinsurance and Annual Deductible information for each Covered Health Service, this section includes descriptions of the Benefits. These descriptions include any additional limitations that may apply, as well as Covered Health Services for which you must call the Claims Administrator or Personal Health Support. The Covered Health Services in this section appear in the same order as they do in the table for easy reference. Services that are not covered are described in Section 8, *Exclusions*.

## Ambulance Services

The Plan covers Emergency ambulance services and transportation provided by a licensed ambulance service to the nearest Hospital that offers Emergency Health Services. See Section 14, *Glossary* for the definition of Emergency.

Ambulance service by air is covered in an Emergency if ground transportation is impossible, or would put your life or health in serious jeopardy. If special circumstances exist, UnitedHealthcare may pay Benefits for Emergency air transportation to a Hospital that is not the closest facility to provide Emergency Health Services.

The Plan also covers transportation provided by a licensed professional ambulance (either ground or air ambulance, as UnitedHealthcare determines appropriate) between facilities when the transport is:

- from a non-Network Hospital to a Network Hospital;
- to a Hospital that provides a higher level of care that was not available at the original Hospital;
- to a more cost-effective acute care facility; or
- from an acute facility to a sub-acute setting.

In most cases, UnitedHealthcare will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, please remember that you must notify Personal Health Support as soon as possible prior to the transport.

## Cancer Resource Services (CRS)

The Plan pays Benefits for oncology services provided by Designated Facilities participating in the Cancer Resource Services (CRS) program. Designated Facility is defined in Section 14, *Glossary*.

For oncology services and supplies to be considered Covered Health Services, they must be provided to treat a condition that has a primary or suspected diagnosis relating to cancer. If you or a covered Dependent has cancer, you may:

- be referred to CRS by the Claims Administrator or a Personal Health Support Nurse;
- call CRS toll-free at (866) 936-6002; or
- visit www. myoptumhealthcomplexmedical.com.

To receive Benefits for a cancer-related treatment, you are not required to visit a Designated Facility. If you receive oncology services from a facility that is not a Designated Facility, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury;
- Physician Fees for Surgical and Medical Services;
- Scopic Procedures - Outpatient Diagnostic and Therapeutic;
- Therapeutic Treatments - Outpatient;
- Hospital - Inpatient Stay; and
- Surgery - Outpatient.

***Note:*** The services described under *Travel and Lodging* are Covered Health Services only in connection with cancer-related services received at a Designated Facility.

To receive Benefits under the CRS program, you must contact CRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CRS program if CRS provides the proper notification to the Designated Facility provider performing the services (even if you self refer to a provider in that Network).

Please remember for Non-Network Benefits, you must notify the Claims Administrator or Personal Health Support. If the Claims Administrator or Personal Health Support is not notified, Benefits will be reduced to 50% of Eligible Expenses.

## Clinical Trials

Benefits are available for routine patient care costs incurred during participation in a qualifying Clinical Trial for the treatment of:

- cancer or other life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted;
- cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as UnitedHealthcare determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below;
- surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, for which, as UnitedHealthcare determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below; and
- other diseases or disorders which are not life threatening for which, as UnitedHealthcare determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from participation in a qualifying Clinical Trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the qualifying Clinical Trial as defined by the researcher.

- Routine patient care costs for qualifying Clinical Trials include:
- Covered Health Services for which Benefits are typically provided absent a Clinical Trial;
- Covered Health Services required solely for the provision of the Experimental or Investigational Service(s) or item, the clinically appropriate monitoring of the effects of the service or item, or the prevention of complications; and
- Covered Health Services needed for reasonable and necessary care arising from the provision of an Experimental or Investigational Service(s) or item.

Routine costs for Clinical Trials do not include:

- the Experimental or Investigational Service(s) or item. The only exceptions to this are:
  - certain Category B devices;
  - certain promising interventions for patients with terminal illnesses; and
  - other items and services that meet specified criteria in accordance with UnitedHealthcare's medical and drug policies;
- items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; and
- items and services provided by the research sponsors free of charge for any person enrolled in the trial.

With respect to cancer or other life-threatening diseases or conditions, a qualifying Clinical Trial is a Phase I, Phase II, Phase III, or Phase IV Clinical Trial that is conducted in relation

to the prevention, detection or treatment of cancer or other life-threatening disease or condition and which meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease or musculoskeletal disorders of the spine, hip and knees and other diseases or disorders which are not life-threatening, a qualifying Clinical Trial is a Phase I, Phase II, or Phase III Clinical Trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and which meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - National Institutes of Health (NIH). (Includes National Cancer Institute (NCI));
  - Centers for Disease Control and Prevention (CDC);
  - Agency for Healthcare Research and Quality (AHRQ);
  - Centers for Medicare and Medicaid Services (CMS);
  - a cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Veterans Administration (VA);
  - a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or
  - The Department of Veterans Affairs, the Department of Defense or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to meet both of the following criteria:
    - comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*; and
    - ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- the study or investigation is conducted under an investigational new drug application reviewed by the *U.S. Food and Drug Administration*;
- the study or investigation is a drug trial that is exempt from having such an investigational new drug application;
- the Clinical Trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (*IRBs*) before participants are enrolled in the trial. UnitedHealthcare may, at any time, request documentation about the trial; or
- the subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Plan.

Please remember for Network and Non-Network Benefits, you must notify the Claims Administrator or Personal Health Support as soon as the possibility of participation in a Clinical Trial arises. If the Claims Administrator or Personal Health Support is not notified, Benefits will be reduced to 50% of Eligible Expenses.

## Congenital Heart Disease (CHD) Surgeries

The Plan pays Benefits for Congenital Heart Disease (CHD) surgeries which are ordered by a Physician. CHD surgical procedures include surgeries to treat conditions such as coarctation of the aorta, aortic stenosis, tetralogy of fallot, transposition of the great vessels and hypoplastic left or right heart syndrome.

UnitedHealthcare has specific guidelines regarding Benefits for CHD services. Contact UnitedHealthcare at the number on your ID card for information about these guidelines.

The Plan pays Benefits for CHD services ordered by a Physician and received at a CHD Resource Services program. Benefits include the facility charge and the charge for supplies and equipment. Benefits are available for the following CHD services:

- outpatient diagnostic testing;
- evaluation;
- surgical interventions;
- interventional cardiac catheterizations (insertion of a tubular device in the heart);
- fetal echocardiograms (examination, measurement and diagnosis of the heart using ultrasound technology); and
- approved fetal interventions.

CHD services other than those listed above are excluded from coverage, unless determined by the Claims Administrator to be proven procedures for the involved diagnoses. Contact CHD Resource Services at (888) 936-7246 before receiving care for information about CHD services. More information is also available at **www.myoptumhealthcomplexmedical.com**

If you receive Congenital Heart Disease services from a facility that is not a Designated Facility, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury;
- Physician Fees for Surgical and Medical Services;
- Scopic Procedures - Outpatient Diagnostic and Therapeutic;
- Therapeutic Treatments – Outpatient;
- Hospital - Inpatient Stay; and
- Surgery - Outpatient.

To receive Benefits under the CHD program, you must contact CHD Resource Services at 1-888-936-7246 prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CHD program if CHD provides the proper notification to the Designated Facility provider performing the services (even if you self refer to a provider in that Network).

***Note:*** The services described under *Travel and Lodging* are Covered Health Services only in connection with CHD services received at a Congenital Heart Disease Resource Services program.

Please remember that for Non-Network Benefits you must notify the Claims Administrator or Personal Health Support as soon as the possibility of participation in a Clinical Trial arises. If the Claims Administrator or Personal Health Support is not notified, Benefits will be reduced to 50% of Eligible Expenses.

## Dental Services - Accident Only

Dental services are covered by the Plan when all of the following are true:

- treatment is necessary because of accidental damage;
- dental services are received from a Doctor of Dental Surgery or a Doctor of Medical Dentistry; and
- the dental damage is severe enough that initial contact with a Physician or dentist occurs within 72 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered having occurred as an accident. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

The Plan also covers dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition limited to:

- dental services related to medical transplant procedures;
- initiation of immunosuppressives (medication used to reduce inflammation and suppress the immune system); and
- direct treatment of acute traumatic Injury, cancer or cleft palate.

Dental services for final treatment to repair the damage caused by accidental Injury must be started within three months of the accident unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care) and completed within 12 months of the accident.

The Plan pays for treatment of accidental Injury only for:

- emergency examination;
- necessary diagnostic x-rays;
- endodontic (root canal) treatment;
- temporary splinting of teeth;

- prefabricated post and core;
- simple minimal restorative procedures (fillings);
- extractions;
- post-traumatic crowns if such are the only clinically acceptable treatment; and
- replacement of lost teeth due to the Injury by implant, dentures or bridges.

Please remember that for Network and Non-Network Benefits, you should notify the Claims Administrator or Personal Health Support as soon as possible, but at least five business days before follow-up (post-Emergency) treatment begins. You do not have to provide notification before the initial Emergency treatment. When you provide notification, the Claims Administrator or Personal Health Support can also determine whether the service is a Covered Health Service.

## Dental Services - Anesthesia and Hospitalization

Benefits include Covered Health Services provided in a Hospital or Alternate Facility for dental conditions likely to result in a medical condition if left untreated.

Benefits are limited to treatment of a Covered Person who:

- is under 8 years of age, and
- is determined by a Physician to require dental treatment in a Hospital or Alternate Facility, due to a complex dental condition or a developmental disability that prevents effective treatment in a dental office; or
- has one or more medical conditions that would create undue medical risk if dental treatment were provided in a dental office.

Benefits do not include expenses for the diagnosis and treatment of dental disease.

Please remember for Network and Non-Network Benefits, you must notify the Claims Administrator or Personal Health Support five business days before admission or as soon as reasonably possible. If the Claims Administrator or Personal Health Support is not notified, Benefits will be reduced or denied.

## Diabetes Services

### *Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care*

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Diabetes outpatient self-management training, education and medical nutrition therapy services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals.

Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes.

***Diabetic Self-Management Items***

Insulin pumps and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person. An insulin pump is subject to all the conditions of coverage stated under Durable Medical Equipment. Benefits for blood glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described is Section 15, *Outpatient Prescription Drugs*.

Please remember for Non-Network Benefits, you must notify the Claims Administrator or Personal Health Support before obtaining any Durable Medical Equipment for the management and treatment of diabetes if the retail purchase cost or cumulative retail, rental cost of a single item will exceed $1,000. You must purchase or rent the DME from the vendor the Claims Administrator or Personal Health Support identifies.

## Durable Medical Equipment (DME)

The Plan pays for Durable Medical Equipment (DME) that is:

- ordered or provided by a Physician for outpatient use;
- used for medical purposes;
- not consumable or disposable;
- not of use to a person in the absence of a Sickness, Injury or disability;
- durable enough to withstand repeated use; and
- appropriate for use in the home.

If more than one piece of DME can meet your functional needs, you will receive Benefits only for the most Cost-Effective piece of equipment. Benefits are provided for a single unit of DME (example: one insulin pump) and for repairs of that unit. If you rent or purchase a piece of Durable Medical Equipment that exceeds this guideline, you may be responsible for any cost difference between the piece you rent or purchase and the piece UnitedHealthcare has determined is the most Cost-Effective.

Examples of DME include but are not limited to:

- equipment to administer oxygen;
- equipment to assist mobility, such as a standard wheelchair;
- Hospital beds;
- delivery pumps for tube feedings;
- burn garments;
- insulin pumps and all related necessary supplies as described under *Diabetes Services* in this section;
- external cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure.

See *Hospital - Inpatient Stay*, *Rehabilitation Services - Outpatient Therapy* and *Surgery - Outpatient* in this section;

- braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices and are excluded from coverage. Dental braces are also excluded from coverage; and
- mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).

The Plan also covers tubings, nasal cannulas, connectors and masks used in connection with DME.

Benefits also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required three-month rental period.

Benefits for speech aid devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Plan.

***Note:*** DME is different from prosthetic devices – see *Prosthetic Devices* in this section.

Please remember for Non-Network Benefits, you must notify the Claims Administrator or Personal Health Support if the retail purchase cost or cumulative rental cost of a single item will exceed $1,000. To receive Network Benefits, you must purchase or rent the DME from the vendor the Claims Administrator or Personal Health Support identifies.

## Emergency Health Services - Outpatient

The Plan's Emergency services Benefit pays for outpatient treatment at a Hospital or Alternate Facility when required to stabilize a patient or initiate treatment.

Network Benefits will be paid for an Emergency admission to a non-Network Hospital as long as the Claims Administrator is notified within two business days of the admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you continue your stay in a non-Network Hospital after the date your Physician determines that it is medically appropriate to transfer you to a Network Hospital, Network Benefits will not be provided .Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service. Eligible Expenses will be determined as described under *Eligible Expenses* in Section 3, *Plan Highlights*.

Benefits under this section are not available for services to treat a condition that does not meet the definition of an Emergency.

## Hearing Aids

The Plan pays Benefits for hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Physician. Benefits are provided for the hearing aid and for charges for associated fitting and testing.

Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Services categories in this section only for Covered Persons who have either of the following:

- craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or
- hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

Benefits are limited to a single purchase (including repair/replacement) per hearing impaired ear every three calendar years for any combination of Network and Non-Network Benefits.

## Hearing Testing

Benefits are available for hearing exams in case of Injury or Sickness when received from a provider in the provider's office.

## Home Health Care

Covered Health Services are services that a Home Health Agency provides if you need care in your home due to the nature of your condition. Services must be:

- ordered by a Physician;
- provided by or supervised by a registered nurse in your home, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse;
- not considered Custodial Care, as defined in Section 14, *Glossary*; and
- provided on a part-time, Intermittent Care schedule when Skilled Care is required. Refer to Section 14, *Glossary* for the definition of Skilled Care.

The Claims Administrator will determine if Skilled Care is needed by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Any combination of Network and Non-Network Benefits is limited to 100 visits per calendar year. One visit equals four hours of Skilled Care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.

Please remember for Non-Network Benefits, you must notify the Claims Administrator or Personal Health Support five business days before receiving services or as soon as reasonably possible. If the Claims Administrator or Personal Health Support is not notified, Benefits will be reduced to 50% of Eligible Expenses.

## Hospice Care

Hospice care is an integrated program recommended by a Physician which provides comfort and support services for the terminally ill. Hospice care can be provided on an inpatient or outpatient basis and includes physical, psychological, social, spiritual and respite care for the terminally ill person, and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a Hospital.

Please remember for Non-Network Benefits, you must notify the Claims Administrator or Personal Health Support five business days before receiving services. If the Claims Administrator or Personal Health Support is not notified, Benefits will be reduced to 50% of Eligible Expenses.

## Hospital - Inpatient Stay

Hospital Benefits are available for:

- non-Physician services and supplies received during an Inpatient Stay;
- room and board in a Semi-private Room (a room with two or more beds); and
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians.

The Plan will pay the difference in cost between a Semi-private Room and a private room only if a private room is necessary according to generally accepted medical practice.

Benefits for an Inpatient Stay in a Hospital are available only when the Inpatient Stay is necessary to prevent, diagnose or treat a Sickness or Injury. Benefits for other Hospital-based Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Benefits for Emergency admissions and admissions of less than 24 hours are described under *Emergency Health Services* and *Surgery - Outpatient, Scopic Procedures – Outpatient Diagnostic and Therapeutic*, and *Therapeutic Treatments - Outpatient*, respectively.

Please remember for Non-Network Benefits, you must notify the Claims Administrator or Personal Health Support as follows:

- for scheduled admissions: five business days before admission or as soon as reasonably possible;
- for non-scheduled admission (including Emergency admissions: within two business days, or as soon as is reasonably possible.

If the Claims Administrator or Personal Health Support is not notified, Benefits will be reduced to 50% of Eligible Expenses.

## Lab, X-Ray and Diagnostics - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility include, but are not limited to:

- lab and radiology/x-ray; and
- mammography.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment; and
- Physician services for radiologists, anesthesiologists and pathologists.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury* in this section.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*. Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services* in this section. CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient* in this section.

## Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility

Benefits under this section include:

- the facility charge and the charge for supplies and equipment; and
- Physician services for radiologists, anesthesiologists and pathologists.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury* in this section. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

## Mental Health Services

Mental Health Services include those received on an inpatient or outpatient basis in a Hospital and an Alternate Facility or in a provider's office.

Benefits include the following services:

- diagnostic evaluations and assessment;
- treatment planning;
- treatment and/or procedures;
- referral services;
- medication management;
- individual, family, therapeutic group and provider-based case management services;
- crisis intervention;
- Partial Hospitalization/Day Treatment;
- services at a Residential Treatment Facility; and
- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Administrator determines coverage for the inpatient treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

### *Special Mental Health Programs and Services*

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Administrator may become available to you as part of your Mental Health Services Benefit. The Mental Health Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your Mental Illness which may not otherwise be covered under this Plan. Any decision to participate in such program or service is at the discretion of the Covered Person and is not mandatory.

Please remember that for Non-Network Benefits, you must notify the MH/SUD Administrator to receive inpatient Benefits. Please call the phone number that appears on your ID card. Without notification, Benefits will be reduced to 50% of Eligible Expenses.

## Nutritional Counseling

The Plan will pay for Covered Health Services for medical education services provided in a Physician's office by an appropriately licensed or healthcare professional when:

- education is required for a disease in which patient self-management is an important component of treatment; and
- there exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Some examples of such medical conditions include, but are not limited to:

- coronary artery disease;
- congestive heart failure;
- severe obstructive airway disease;
- gout (a form of arthritis);
- renal failure;
- phenylketonuria (a genetic disorder diagnosed at infancy); and
- hyperlipidemia (excess of fatty substances in the blood).

When nutritional counseling services are billed as a preventive care service, these services will be paid as described under *Preventive Care Services* in this section.

## Ostomy Supplies

Benefits for ostomy supplies are limited to:

- pouches, face plates and belts;
- irrigation sleeves, bags and ostomy irrigation catheters; and
- skin barriers.

## Pharmaceutical Products - Outpatient

The Plan pays for Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home. Examples of what would be included under this category are antibiotic injections in the Physician's office or inhaled medication in an urgent care center for treatment of an asthma attack.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy.

UnitedHealthcare may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at **www.myuhc.com** or by calling the number on your ID card.

## Physician Fees for Surgical and Medical Services

The Plan pays Physician fees for surgical procedures and other medical care received from a Physician in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility, Alternate Facility, or for Physician house calls.

## Physician's Office Services - Sickness and Injury

Benefits are paid by the Plan for Covered Health Services received in a Physician's office for the evaluation and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is free-standing, located in a clinic or located in a Hospital. Benefits under this section include allergy injections and hearing exams in case of Injury or Sickness.

Covered Health Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing which is ordered by the Physician and authorized in advance by UnitedHealthcare.

Benefits for preventive services are described under *Preventive Care Services* in this section.

**Please Note**
Your Physician does not have a copy of your SPD, and is not responsible for knowing or communicating your Benefits.

## Pregnancy - Maternity Services

Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

The Plan will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a vaginal delivery; or
- 96 hours for the mother and newborn child following a cesarean section delivery.

These are federally mandated requirements under the Newborns' and Mothers' Health Protection Act of 1996 which apply to this Plan. The Hospital or other provider is not required to get authorization for the time periods stated above. Authorizations are required for longer lengths of stay. If the mother agrees, the attending Physician may discharge the mother and/or the newborn child earlier than these minimum timeframes.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

Please remember for Non-Network Benefits, you must notify the Claims Administrator or Personal Health Support as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be longer than the timeframes indicated above.

**Healthy moms and babies**
The Plan provides a special prenatal program to help during Pregnancy. Participation is voluntary and free of charge. See Section 7, *Resources to Help you Stay Healthy*, for details.

## Preventive Care Services

The Plan pays for services for preventive medical care provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital.

In general, the Plan pays preventive care Benefits for the following items and services:

- Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (the "Task Force") with respect to the individual involved (but note that the recommendations of the Task Force regarding breast cancer screening, mammography, and prevention issued in or around November 2009 are not considered to be current);
- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention with respect to the individual involved; Immunization coverage includes the Human papillomavirus (HPV) vaccine for females and males based on ACIP provided GUIDANCE of those aged 9 through 26 years;
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and
- With respect to women, to the extent not described in the first bulleted item above, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Preventive care Benefits defined under the Health Resources and Services Administration requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Benefits for breast pumps also include the cost of purchasing one breast pump per Pregnancy in conjunction with childbirth. These Benefits are described under Section 5, *Plan Highlights,* under *Covered Health Services.*

If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump. The Claims Administrator will determine the following:

- which pump is the most cost effective;
- whether the pump should be purchased or rented;
- duration of a rental;
- timing of an acquisition;

Benefits are only available if breast pumps are obtained from a DME provider or Physician.

Benefits for the above-listed items and services will be provided for plan years that begin on or after January 1, 2011, or, if later, for plan years that begin on or after the date that is one year after the date the recommendation or guideline is issued. The Plan is not required to provide Benefits for any item or service that has ceased to be a recommended preventive care item or service under the above recommendations and guidelines.

Other preventive care services not listed under the above recommendations and guidelines may be covered as well. Your Physician may recommend additional services based on your family or medical history. Examples of preventive medical care are listed below and provide a guide of what is considered a Covered Health Service.

Examples of Covered Health Services for preventive care include:

| **Covered Preventive Care Services** | |
|---|---|
| Physician Office Services | ■ routine physical including vision and hearing screenings;<br>■ metabolic screening tests (including phenylketonuria (PKU));<br>■ immunizations;<br>■ well baby and well child care;<br>■ routine gynecological exam including breast and pelvic examination, treatment of minor infections, and PAP test; and<br>■ preventive screenings for obesity. |

| Covered Preventive Care Services | |
|---|---|
| Lab, X-ray or Other Preventive Tests | ■ mammogram;<br>■ colorectal cancer screening;<br>■ cervical cancer screening;<br>■ PSA blood test and digital rectal exam; and<br>■ bone mineral density tests. |

For questions about your preventive care Benefits under this Plan call the number on the back of your ID card.

### Private Duty Nursing - Outpatient

The Plan covers Private Duty Nursing care given on an outpatient basis by a licensed nurse such as a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.).

### Prosthetic Devices

Benefits are paid by the Plan for external prosthetic devices that replace a limb or body part:

- artificial arms, legs, feet and hands;
- artificial face, eyes, ears and nose; and
- breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. Benefits include mastectomy bras and lymphedema stockings for the arm.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. The device must be ordered or provided either by a Physician, or under a Physician's direction. If you purchase a prosthetic device that exceeds these minimum specifications, the Plan will pay only the amount that would have paid for the prosthetic that meets the minimum specifications, and you may be responsible for paying any difference in cost.

Benefits are available for repairs and replacement, except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices.

Benefits are limited to a single purchase of each type of prosthetic device every three calendar years.

***Note:*** Prosthetic devices are different from DME - see *Durable Medical Equipment (DME)* in this section.

## Reconstructive Procedures

Reconstructive procedures are services performed when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function for an organ or body part. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Improving or restoring physiologic function means that the organ or body part is made to work better. An example of a reconstructive procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored.

Benefits for reconstructive procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Replacement of an existing breast implant is covered by the Plan if the initial breast implant followed mastectomy. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact UnitedHealthcare at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. Cosmetic procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. A good example is upper eyelid surgery.

At times, this procedure will be done to improve vision, which is considered a reconstructive procedure. In other cases, improvement in appearance is the primary intended purpose, which is considered a Cosmetic Procedure. This Plan does not provide Benefits for Cosmetic Procedures, as defined in Section 14, *Glossary*.

The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Please remember that for Network and Non-Network Benefits, you must notify the Claims Administrator or Personal Health Support five business days before undergoing a Reconstructive Procedure. When you provide notification, the Claims Administrator or Personal Health Support can determine whether the service is considered reconstructive or cosmetic. Cosmetic Procedures are always excluded from coverage. If the Claims Administrator or Personal Health Support is not notified, Benefits will be reduced to 50% of Eligible Expenses.

In addition, for Non-Network Benefits you must contact the Claims Administrator 24 hours before admission for scheduled inpatient admissions or as soon as is reasonably possible for non-scheduled inpatient admissions (including Emergency admissions.)

## Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

The Plan provides short-term outpatient rehabilitation services (including habilitative services) limited to:

- physical therapy;
- occupational therapy;
- Manipulative Treatment;
- speech therapy;
- post-cochlear implant aural therapy;
- pulmonary rehabilitation; and
- cardiac rehabilitation.

For all rehabilitation services, a licensed therapy provider, under the direction of a Physician (when required by state law), must perform the services. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility.

### *Habilitative Services*

Benefits are provided for habilitative services provided on an outpatient basis for Covered Persons with a congenital, genetic, or early acquired disorder when both of the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist, Physician, licensed nutritionist, licensed social worker or licensed psychologist.
- The initial or continued treatment must be proven and not Experimental or Investigational.

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and residential treatment are not habilitative services. A service that does not help the Covered Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service. When the Covered Person reaches his/her maximum level of improvement or does not demonstrate continued progress under a treatment plan, a service that was previously habilitative is no longer habilitative.

The Plan may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow the Plan to substantiate that initial or continued

medical treatment is needed and that the Covered Person's condition is clinically improving as a result of the habilitative service. When the treating provider anticipates that continued treatment is or will be required to permit the Covered Person to achieve demonstrable progress, the Plan may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

For purposes of this benefit, the following definitions apply:

- "Habilitative services" means occupational therapy, physical therapy and speech therapy prescribed by the Covered Person's treating Physician pursuant to a treatment plan to develop a function not currently present as a result of a congenital, genetic, or early acquired disorder.
- A "congenital or genetic disorder" includes, but is not limited to, hereditary disorders.
- An "early acquired disorder" refers to a disorder resulting from Sickness, Injury, trauma or some other event or condition suffered by a Covered Person prior to that Covered Person developing functional life skills such as, but not limited to, walking, talking, or self-help skills.

Other than as described under Habilitative Services above, please note the Plan will pay Benefits for speech therapy only when the speech impediment or dysfunction results from Injury, Sickness, stroke, cancer, or a Congenital Anomaly, or is needed following the placement of a cochlear implant.

Additionally, the Plan will pay Benefits for speech therapy for children under the age of 3 whose speech is impaired due to one of the following conditions;

- infantile autism;
- developmental delay or cerebral palsy; and
- hearing impairment.

Any combination of Network and Non-Network Benefits for any combination of physical therapy, occupational therapy, speech therapy, are limited to 60 visits per calendar year.

### Scopic Procedures - Outpatient Diagnostic and Therapeutic

The Plan pays for diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and endoscopy.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment; and

- Physician services for radiologists, anesthesiologists and pathologists.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury* in this section. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

When these services are performed for preventive screening purposes, Benefits are described in this section under *Preventive Care Services*.

## Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Facility services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility are covered by the Plan. Benefits include:

- Supplies and non-Physician services received during the Inpatient Stay;
- room and board in a Semi-private Room (a room with two or more beds); and
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits are available when skilled nursing and/or Inpatient Rehabilitation Facility services are needed on a daily basis. Benefits are also available in a Skilled Nursing Facility or Inpatient Rehabilitation Facility for treatment of a Sickness or Injury that would have otherwise required an Inpatient Stay in a Hospital.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

UnitedHealthcare will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are available only if both of the following are true:

- the initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a Cost Effective alternative to an Inpatient Stay in a Hospital; and
- you will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:

- it is delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient;
- it is ordered by a Physician;

- it is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair; and
- it requires clinical training in order to be delivered safely and effectively.

You are expected to improve to a predictable level of recovery. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

***Note:*** The Plan does not pay Benefits for Custodial Care or Domiciliary Care, even if ordered by a Physician, as defined in Section 14, *Glossary*.

Please remember for Non-Network Benefits, you must notify the Claims Administrator or Personal Health Support as follows:
- for a scheduled admission: five business days before admission;
- for non-scheduled admissions: within two business days, or as soon as is reasonably possible.

If the Claims Administrator or Personal Health Support is not notified, Benefits will be reduced to 50% of Eligible Expenses.

In addition, for Non-Network Benefits you must contact the Claims Administrator or Personal Health Support 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

## Substance Use Disorder Services

Substance Use Disorder Services (also known as substance-related and addictive disorders services) include those received on an inpatient or outpatient basis in a Hospital or an Alternate Facility

Benefits include the following services:

- diagnostic evaluations and assessment;
- treatment planning;
- treatment and/or procedures;
- referral services;
- medication management;
- individual, family, therapeutic group and provider-based case management;
- crisis intervention;
- Partial Hospitalization/Day Treatment;
- services at a Residential Treatment Facility; and
- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Administrator determines coverage for the inpatient treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

***Special Substance Use Disorder Programs and Services***

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Administrator may become available to you as part of your Substance Use Disorder Services Benefit. The Substance Use Disorder Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your substance use disorder which may not otherwise be covered under this Plan. Any decision to participate in such program or service is at the discretion of the Covered Person and is not mandatory.

Please remember that for Non-Network Benefits, you must notify the MH/SUD Administrator to receive inpatient Benefits. Please call the phone number that appears on your ID card. Without notification, Benefits will be reduced to 50% of Eligible Expenses.

## Surgery - Outpatient

The Plan pays for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment;
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

## Therapeutic Treatments - Outpatient

The Plan pays Benefits for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including but not limited to dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when:

- education is required for a disease in which patient self-management is an important component of treatment; and
- there exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include:

- the facility charge and the charge for related supplies and equipment; and
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services*.

Please remember for Non-Network Benefits, you must notify the Claims Administrator or Personal Health Support five business days before scheduled dialysis services are received or, for non-scheduled services, within one business day or as soon as reasonably possible. If the Claims Administrator or Personal Health Support is not notified, Benefits will be reduced to 50% of Eligible Expenses.

## Transplantation Services

Organ and tissue transplants when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include bone marrow, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.

Benefits are available to the donor and the recipient when the recipient is covered under this Plan. Donor cost that are directly related to organ removal or procurement are Covered Health Services. for which Benefits are payable through the organ recipient's coverage under the Plan.

The Claims Administrator has specific guidelines regarding Benefits for transplant services. Contact the Claims Administrator at the number on your ID card for information about these guidelines.

Transplantation services including evaluation for transplant, organ procurement and donor searches and transplantation procedures may be received at a Designated Facility, Network facility that is not a Designated Facility or a non-Network facility.

Benefits are also available for cornea transplants. You are not required to notify the Claims Administrator or Personal Health Support of a cornea transplant nor is the cornea transplant required to be performed at a Designated Facility.

Non-Network Benefits are limited to $30,000 per transplant.

***Note:*** The services described under *Travel and Lodging* are Covered Health Services only in connection with transplant services received at a Designated Facility.

For Network Benefits, you must notify the Claims Administrator or Personal Health Support as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you do not notify the Claims Administrator or Personal Health Support, and if, as a result, the services are not performed at a Designated Facility, Network Benefits will not be paid. Non-Network Benefits will apply.

For Non-Network Benefits, you must notify the Claims Administrator or Personal Health Support as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If the Claims Administrator or Personal Health Support is not notified, Benefits will be reduced to 50% of Eligible Expenses.

In addition, for Non-Network Benefits you must contact the Claims Administrator or Personal Health Support 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

**Support in the event of serious illness**
If you or a covered family member needs an organ or bone marrow transplant, UnitedHealthcare can put you in touch with quality treatment centers around the country.

## Travel and Lodging

The Claims Administrator will assist the patient and family with travel and lodging arrangements related to:

- Congenital Heart Disease (CHD);
- transplantation services; and
- cancer-related treatments.

For travel and lodging services to be covered, the patient must be receiving services at a Designated Facility.

### *Travel and Lodging Expenses*

The Plan covers expenses for travel and lodging for the patient, provided he or she is not covered by Medicare, and a companion as follows:

- transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the cancer-related treatment, the CHD service, or the transplant for the purposes of an evaluation, the procedure or necessary post-discharge follow-up;

- Eligible Expenses for lodging for the patient (while not a Hospital inpatient) and one companion. Benefits are paid at a per diem (per day) rate of up to $50 per day for the patient or up to $100 per day for the patient plus one companion; or
- if the patient is an enrolled Dependent minor child, the transportation expenses of two companions will be covered and lodging expenses will be reimbursed at a per diem rate up to $100 per day.

Travel and lodging expenses are only available if the recipient lives more than 50 miles from the Designated Facility (for CRS and transplantation) or the CHD facility. UnitedHealthcare must receive valid receipts for such charges before you will be reimbursed. Examples of travel expenses may include:

- airfare at coach rate;
- taxi or ground transportation; or
- mileage reimbursement at the IRS rate for the most direct route between the patient's home and the Designated Facility.

A combined overall maximum Benefit of $10,000 per Covered Person applies for all travel and lodging expenses reimbursed under this Plan in connection with cancer treatments, transplant procedures and CHD treatments during the entire period that person is covered under this Plan.

**Support in the event of serious illness**
If you or a covered family member has cancer or needs an organ or bone marrow transplant, UnitedHealthcare can put you in touch with quality treatment centers around the country.

## Urgent Care Center Services

The Plan provides Benefits for services, including professional services, received at an Urgent Care Center, as defined in Section 14, *Glossary*. When Urgent Care services are provided in a Physician's office, the Plan pays Benefits as described under *Physician's Office Services - Sickness and Injury* earlier in this section.

## Vision Examinations

The Plan pays Benefits for:

- vision screenings, which could be performed as part of an annual physical examination in a provider's office (vision screenings include refractive examinations to detect vision impairment); and
- one routine vision exam, including refraction, to detect vision impairment by a provider in the provider's office every calendar year.

## Wigs

The Plan pays Benefits for wigs and other scalp hair prosthesis only for loss of hair resulting from malignancy or if there is permanent hair loss due to an accidental injury.

# SECTION 7 - RESOURCES TO HELP YOU STAY HEALTHY

**What this section includes:**
Health and well-being resources available to you, including:

- Consumer Solutions and Self-Service Tools;
- Disease and Condition Management Services; and
- Wellness Programs.

Lockton, Inc. believes in giving you the tools you need to be an educated health care consumer. To that end, Lockton, Inc. has made available several convenient educational and support services, accessible by phone and the Internet, which can help you to:

- take care of yourself and your family members;
- manage a chronic health condition; and
- navigate the complexities of the health care system.

***NOTE:***
Information obtained through the services identified in this section is based on current medical literature and on Physician review. It is not intended to replace the advice of a doctor. The information is intended to help you make better health care decisions and take a greater responsibility for your own health. UnitedHealthcare and Lockton, Inc. are not responsible for the results of your decisions from the use of the information, including, but not limited to, your choosing to seek or not to seek professional medical care, or your choosing or not choosing specific treatment based on the text.

## Consumer Solutions and Self-Service Tools

### *Health Assessment*

You and your Spouse or Domestic Partner are invited to learn more about your health and wellness at **www.myuhc.com** and are encouraged to participate in the online health assessment. The health assessment is an interactive questionnaire designed to help you identify your healthy habits as well as potential health risks.

Your health assessment is kept confidential. Completing the assessment will not impact your Benefits or eligibility for Benefits in any way.

To find the health assessment, log in to **www.myuhc.com**. After logging in, access your personalized *Health & Wellness* page and click the *Health Assessment* link. If you need any assistance with the online assessment, please call the number on the back of your ID card.

### *Health Improvement Plan*

You can start a Health Improvement Plan at any time. This plan is created just for you and includes information and interactive tools, plus online health coaching recommendations based on your profile.

Online coaching is available for:

- nutrition;
- exercise;
- weight management;
- stress;
- smoking cessation;
- diabetes; and
- heart health.

To help keep you on track with your Health Improvement Plan and online coaching, you'll also receive personalized messages and reminders – Lockton, Inc.'s way of helping you meet your health and wellness goals.

### *NurseLine℠*

NurseLine℠ is a toll-free telephone service that puts you in immediate contact with an experienced registered nurse any time, 24 hours a day, seven days a week. Nurses can provide health information for routine or urgent health concerns. When you call, a registered nurse may refer you to any additional resources that Lockton, Inc. has available to help you improve your health and well-being or manage a chronic condition. Call any time when you want to learn more about:

- a recent diagnosis;
- a minor Sickness or Injury;
- men's, women's, and children's wellness;
- how to take Prescription Drug Products safely;
- self-care tips and treatment options;
- healthy living habits; or
- any other health related topic.

NurseLine℠ gives you another convenient way to access health information. By calling the same toll-free number, you can listen to one of the Health Information Library's over 1,100 recorded messages, with over half in Spanish.

NurseLine℠ is available to you at no cost. To use this convenient service, simply call the number on the back of your ID card.

***Note:*** If you have a medical emergency, call 911 instead of calling NurseLine℠.

**Your child is running a fever and it's 1:00 AM. What do you do?**
Call NurseLine℠ toll-free, any time, 24 hours a day, seven days a week. You can count on NurseLine℠ to help answer your health questions.

With NurseLine℠, you also have access to nurses online. To use this service, log onto **www.myuhc.com** and click "Live Nurse Chat" in the top menu bar. You'll instantly be connected with a registered nurse who can answer your general health questions any time, 24 hours a day, seven days a week. You can also request an e-mailed transcript of the conversation to use as a reference.

***Note:*** If you have a medical emergency, call 911 instead of logging onto **www.myuhc.com**.

### *Treatment Decision Support*

In order to help you make informed decisions about your health care, UnitedHealthcare has a program called Treatment Decision Support. This program targets specific conditions as well as the treatments and procedures for those conditions.

This program offers:

- access to accurate, objective and relevant health care information;
- coaching by a nurse through decisions in your treatment and care;
- expectations of treatment; and
- information on high quality providers and programs.

Conditions for which this program is available include:

- back pain;
- knee & hip replacement;
- prostate disease;
- prostate cancer;
- benign uterine conditions;
- breast cancer; and
- coronary disease.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on the back of your ID card.

### *UnitedHealth Premium® Program*

To help people make more informed choices about their health care, the *UnitedHealth Premium*® program recognizes Network Physicians who meet standards for quality and cost efficiency. UnitedHealthcare uses evidence-based medicine and national industry guidelines to evaluate quality. The cost efficiency standards rely on local market benchmarks for the efficient use of resources in providing care.

For details on the UnitedHealth Premium® Program including how to locate a UnitedHealth Premium® Physician or facility, log onto **www.myuhc.com** or call the toll-free number on your ID card.

***www.myuhc.com***

UnitedHealthcare's member website, **www.myuhc.com**, provides information at your fingertips anywhere and anytime you have access to the Internet. **www.myuhc.com** opens the door to a wealth of health information and convenient self-service tools to meet your needs.

With **www.myuhc.com** you can:

- research a health condition and treatment options to get ready for a discussion with your Physician;
- search for Network providers available in your Plan through the online provider directory;
- access all of the content and wellness topics from NurseLine℠ including Live Nurse Chat 24 hours a day, seven days a week;
- complete a health risk assessment to identify health habits you can improve, learn about healthy lifestyle techniques and access health improvement resources;
- use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area; and
- use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

**Registering on www.myuhc.com**
If you have not already registered as a **www.myuhc.com** subscriber, simply go to **www.myuhc.com** and click on "Register Now." Have your ID card handy. The enrollment process is quick and easy.

Visit **www.myuhc.com** and:

- make real-time inquiries into the status and history of your claims;
- view eligibility and Plan Benefit information, including Annual Deductibles;
- view and print all of your Explanation of Benefits (EOBs) online; and
- order a new or replacement ID card or, print a temporary ID card.

**Want to learn more about a condition or treatment?**
Log on to **www.myuhc.com** and research health topics that are of interest to you. Learn about a specific condition, what the symptoms are, how it is diagnosed, how common it is, and what to ask your Physician.

## Disease and Condition Management Services

### *Cancer Support Program*

UnitedHealthcare provides a program that identifies, assesses, and supports members who have cancer. The program is designed to support you. This means that you may be called by a registered nurse who is a specialist in cancer and receive free educational information through the mail. You may also call the program and speak with a nurse whenever you need to. This nurse will be a resource and advocate to advise you and to help you manage your condition. This program will work with you and your Physicians, as appropriate, to offer education on cancer, and self-care strategies and support in choosing treatment options.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please call the number on the back of your ID card or call the program directly at (866) 936-6002.

For information regarding specific Benefits for cancer treatment within the Plan, see Section 6, *Additional Coverage Details* under the heading *Cancer Resource Services (CRS)*.

### *Disease Management Services*

If you have been diagnosed with or are at risk for developing certain chronic medical conditions you may be eligible to participate in a disease management program at no cost to you. The heart failure, coronary artery disease, diabetes and asthma programs are designed to support you. This means that you will receive free educational information through the mail, and may even be called by a registered nurse who is a specialist in your specific medical condition. This nurse will be a resource to advise and help you manage your condition.

These programs offer:

- educational materials mailed to your home that provide guidance on managing your specific chronic medical condition. This may include information on symptoms, warning signs, self-management techniques, recommended exams and medications;
- access to educational and self-management resources on a consumer website;
- an opportunity for the disease management nurse to work with your Physician to ensure that you are receiving the appropriate care; and
- toll-free access to and one-on-one support from a registered nurse who specializes in your condition. Examples of support topics include:
  - education about the specific disease and condition,
  - medication management and compliance,
  - reinforcement of on-line behavior modification program goals,
  - preparation and support for upcoming Physician visits,
  - review of psychosocial services and community resources,
  - caregiver status and in-home safety,
  - use of mail-order pharmacy and Network providers.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on the back of your ID card.

### *HealtheNotes℠*

UnitedHealthcare provides a service called HealtheNotes℠ to help educate members and make suggestions regarding your medical care. HealtheNotes℠ provides you and your Physician with suggestions regarding preventive care, testing or medications, potential interactions with medications you have been prescribed, and certain treatments. In addition, your HealtheNotes℠ report may include health tips and other wellness information.

UnitedHealthcare makes these suggestions through a software program that provides retrospective, claims-based identification of medical care. Through this process patients are identified whose care may benefit from suggestions using the established standards of evidence based medicine as described in Section 14, *Glossary* under the definition of Covered Health Services.

If your Physician identifies any concerns after reviewing his or her HealtheNotes℠ report, he or she may contact you if he or she believes it to be appropriate. In addition, you may use the information in your report to engage your Physician in discussions regarding your health and the identified suggestions. Any decisions regarding your care, though, are always between you and your Physician.

If you have questions or would like additional information about this service, please call the number on the back of your ID card.

## Wellness Programs

### *Healthy Pregnancy Program*

If you are pregnant and enrolled in the medical Plan, you can get valuable educational information and advice by calling the toll-free number on your ID card. This program offers:

- pregnancy consultation to identify special needs;
- written and on-line educational materials and resources;
- 24-hour toll-free access to experienced maternity nurses;
- a phone call from a care coordinator during your Pregnancy, to see how things are going; and
- a phone call from a care coordinator approximately four weeks postpartum to give you information on infant care, feeding, nutrition, immunizations and more.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first 12 weeks of Pregnancy. You can enroll any time, up to your 34th week. To enroll, call the toll-free number on the back of your ID card.

As a program participant, you can call any time, 24 hours a day, seven days a week, with any questions or concerns you might have.

# SECTION 8 - EXCLUSIONS AND LIMITATIONS: WHAT THE MEDICAL PLAN WILL NOT COVER

**What this section includes:**

- Services, supplies and treatments that are not Covered Health Services, except as may be specifically provided for in Section 6, *Additional Coverage Details*.

The Plan does not pay Benefits for the following services, treatments or supplies even if they are recommended or prescribed by a provider or are the only available treatment for your condition.

When Benefits are limited within any of the Covered Health Services categories described in Section 6, *Additional Coverage Details*, those limits are stated in the corresponding Covered Health Service category in Section 5, *Plan Highlights*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in Section 5, *Plan Highlights*. Please review all limits carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed these benefit limits.

**Please note that in listing services or examples, when the SPD says "this includes," or "including but not limiting to", it is not UnitedHealthcare's intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the SPD specifically states that the list "is limited to."**

## Alternative Treatments

1. acupressure;
2. acupuncture;
3. aromatherapy;
4. hypnotism;
5. massage therapy;
6. rolfing (holistic tissue massage); and
7. art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in Section 6, *Additional Coverage Details*.

## Dental

1. dental care, except as identified under *Dental Services - Accident Only* and *Dental Services - Anesthesia and Hospitalization* in Section 6, *Additional Coverage Details*;

Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded.

2. preventive care and diagnosis or treatment of or related to the teeth, jawbones or gums. Examples include:

   - extractions (including wisdom teeth);
   - restoration and replacement of teeth;
   - medical or surgical treatments of dental conditions; and
   - services to improve dental clinical outcomes.

   This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services – Accident Only* in Section 6, *Additional Coverage Details*.

3. dental implants, bone grafts, and other implant-related procedures;

   This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services – Accident Only* in Section 6, *Additional Coverage Details*.

4. dental braces (orthodontics);

5. dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia except as identified under *Dental Services - Anesthesia and Hospitalization* in Section 6, *Additional Coverage Details*; and

   This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan, as identified in Section 6, *Additional Coverage Details*.

6. treatment of congenitally missing (when the cells responsible for the formation of the tooth are absent from birth), malpositioned or supernumerary (extra) teeth, even if part of a Congenital Anomaly such as cleft lip or cleft palate.

## Devices, Appliances and Prosthetics

1. devices used specifically as safety items or to affect performance in sports-related activities;

2. orthotic appliances and devices that straighten or re-shape a body part, except as described under *Durable Medical Equipment (DME)* in Section 6, *Additional Coverage Details*.

Examples of excluded orthotic appliances and devices include but are not limited to, foot orthotics or any orthotic braces available over-the-counter. This exclusion does not include diabetic footwear which may be covered for a Covered Person with diabetic foot disease.

3. cranial banding;

4. the following items are excluded, even if prescribed by a Physician:

   - blood pressure cuff/monitor;
   - enuresis alarm;
   - non-wearable external defibrillator;
   - trusses; and
   - ultrasonic nebulizers.

5. the repair and replacement of prosthetic devices when damaged due to misuse, malicious breakage or gross neglect;

6. the replacement of lost or stolen prosthetic devices;

7. devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment* in Section 6, *Additional Coverage Details*; and

8. oral appliances for snoring.

## Drugs

The exclusions listed below apply to the medical portion of the Plan only. Prescription Drug coverage is excluded under the medical plan because it is a separate benefit. Coverage may be available under the Prescription Drug portion of the Plan. See Section 15, *Outpatient Prescription Drugs*, for coverage details and exclusions.

1. Prescription Drug Products for outpatient use that are filled by a prescription order or refill;

2. self-injectable medications (This exclusion does not apply to medications which, due to their characteristics, as determined by UnitedHealthcare, must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting);

3. growth hormone therapy;

4. non-injectable medications given in a Physician's office except as required in an Emergency and consumed in the Physician's office; and

5. over the counter drugs and treatments.

## Experimental or Investigational or Unproven Services

1. Experimental or Investigational Services or Unproven Services, unless the Plan has agreed to cover them as defined in Section 14, *Glossary*.

This exclusion applies even if Experimental or Investigational Services or Unproven Services, treatments, devices or pharmacological regimens are the only available treatment options for your condition.

This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 6, *Additional Coverage Details*.

## Foot Care

1. routine foot care, except when needed for severe systemic disease or preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under *Diabetes Services* in Section 6, *Additional Coverage Details*. Routine foot care services that are not covered include:

   - cutting or removal of corns and calluses;
   - nail trimming or cutting; and
   - debriding (removal of dead skin or underlying tissue).

2. hygienic and preventive maintenance foot care. Examples include:

   - cleaning and soaking the feet;
   - applying skin creams in order to maintain skin tone; and
   - other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot.

   This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.

3. treatment of flat feet;

4. shoe inserts;

5. arch supports;

6. shoes (standard or custom), lifts and wedges; and

7. shoe orthotics.

## Medical Supplies and Equipment

1. prescribed or non-prescribed medical supplies. Examples of supplies that are not covered include, but are not limited to:

   - ace bandages,
   - diabetic strips, and syringes.

   This exclusion does not apply to:

   - ostomy bags and related supplies for which Benefits are provided as described under *Ostomy Supplies* in Section 6, *Additional Coverage Details*;

- disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Diabetes Services* in Section 6, *Additional Coverage Details*; or
- diabetic supplies for which Benefits are provided as described under *Diabetes Services* in Section 6, *Additional Coverage Details*.

2. tubings, nasal cannulas, connectors and masks except when used with Durable Medical Equipment;

3. the repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect;

4. the replacement of lost or stolen Durable Medical Equipment; and

5. deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover or other items that are not specifically identified under *Ostomy Supplies* in Section 6, *Additional Coverage Details*.

## Mental Health/Substance Use Disorder

In addition to all other exclusions listed in this Section 8, *Exclusions and Limitations*, the exclusions listed directly below apply to services described under *Mental Health Services*, and/or *Substance Use Disorder Services* in Section 6, *Additional Coverage Details*.

1. services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;

2. services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance use disorders that, in the reasonable judgment of the Mental Health/Substance Use Disorder Administrator, are any of the following:

   - not consistent with generally accepted standards of medical practice for the treatment of such conditions;
   - not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental;
   - not consistent with the Mental Health/Substance Use Disorder Administrator's level of care guidelines or best practices as modified from time to time; or
   - not clinically appropriate for the patient's Mental Illness, Substance Use Disorder or condition based on generally accepted standards of medical practice and benchmarks.

3. Mental Health Services as treatments for R and T code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;

4. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep-wake disorders, feeding disorders, binge eating disorders, neurological disorders and other disorders with a known physical basis;

5. treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilic disorder;

6. educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning;

7. tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*;

8. learning, motor disorders and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;

9. intellectual disabilities and autism spectrum disorder as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;

10. Mental Health Services as a treatment for other conditions that may be a focus of clinical attention as listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;

11. all unspecified disorders in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;

12. methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction;

13. intensive behavioral therapies such as applied behavioral analysis for autism spectrum disorders; and

14. any treatments or other specialized services designed for autism spectrum disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.

## Nutrition

1. nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy;

2. nutritional counseling for either individuals or groups, except as identified under *Diabetes Services*, and except as defined under *Nutritional Counseling* in Section 6, *Additional Coverage Details*;

3. food of any kind. Foods that are not covered include:

   - enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk, even if they are the only source of nutrition and even if they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU). Infant formula available over the counter is always excluded;

- foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes;
- oral vitamins and minerals;
- meals you can order from a menu, for an additional charge, during an Inpatient Stay; and
- other dietary and electrolyte supplements.

4. health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

## Personal Care, Comfort or Convenience

1. television;

2. telephone;

3. beauty/barber service;

4. guest service;

5. supplies, equipment and similar incidentals for personal comfort. Examples include:

   - air conditioners;
   - air purifiers and filters;
   - batteries and battery chargers;
   - dehumidifiers and humidifiers;
   - ergonomically correct chairs;
   - non-Hospital beds, comfort beds, motorized beds and mattresses;
   - breast pumps (This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement.);
   - car seats;
   - chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, and recliners;
   - electric scooters;
   - exercise equipment and treadmills;
   - hot tubs, Jacuzzis, saunas and whirlpools;
   - medical alert systems;
   - music devices;
   - personal computers;
   - pillows;
   - power-operated vehicles;
   - radios;
   - strollers;
   - safety equipment;
   - vehicle modifications such as van lifts;
   - video players; and
   - home modifications to accommodate a health need (including, but not limited to, ramps, swimming pools, elevators, handrails, and stair glides).

## Physical Appearance

1. Cosmetic Procedures, as defined in Section 14, *Glossary*, are excluded from coverage. Examples include:

   - liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple;
   - pharmacological regimens;
   - nutritional procedures or treatments;
   - tattoo or scar removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures);
   - hair removal or replacement by any means;
   - treatments for skin wrinkles or any treatment to improve the appearance of the skin;
   - treatment for spider veins;
   - skin abrasion procedures performed as a treatment for acne;
   - treatments for hair loss;
   - varicose vein treatment of the lower extremities, when it is considered cosmetic; and
   - replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure.

2. physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, health club memberships and programs, spa treatments, and diversion or general motivation;

3. weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity;

4. wigs regardless of the reason for hair loss, except for wigs covered under prosthetics for hair loss due to malignancy or if there is permanent hair loss due to an accidental injury; and

5. treatment of benign gynecomastia (abnormal breast enlargement in males).

## Procedures and Treatments

1. biofeedback;

2. medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea (a sleep disorder in which a person regularly stops breathing for 10 seconds or longer);

3. rehabilitation services and Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including but not limited to routine, long-term or maintenance/preventive treatment;

4. speech therapy to treat stuttering, stammering, or other articulation disorders;

5. speech therapy, except when required for treatment of a speech impediment or speech dysfunction that results from Injury, Sickness, stroke, cancer, a Congenital Anomaly or is needed following the placement of a cochlear implant or as identified under *Rehabilitation Services – Outpatient Therapy and Manipulative Treatment* in Section 6, *Additional Coverage Details*;

6. a procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy;

7. excision or elimination of hanging skin on any part of the body (examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty);

8. psychosurgery (lobotomy);

9. treatment of tobacco dependency;

10. chelation therapy, except to treat heavy metal poisoning;

11. Manipulative Treatment to treat a condition unrelated to spinal manipulation and ancillary physiologic treatment rendered to restore/improve motion, reduce pain and improve function, alignment of the vertebral column, such as asthma or allergies;

12. physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter;

13. sex transformation operations;

14. the following treatments for obesity:

    - non-surgical treatment, even if for morbid obesity; and
    - surgical treatment of obesity even if there is a diagnosis of morbid obesity.

15. medical and surgical treatment of hyperhidrosis (excessive sweating);

16. services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), when the services are considered medical or dental in nature;

17. upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury, dislocation, tumor or cancer. Orthognathic surgery (procedure to correct underbite or overbite) jaw alignment and treatment for the temporomandibular joint, except as treatment of obstructive sleep apnea; and

18. breast reduction surgery that is determined to be a Cosmetic Procedure.

    This exclusion does not apply to breast reduction surgery which the Claims Administrator determines is requested to treat a physiologic functional impairment or to coverage required by the Women's Health and Cancer Right's Act of 1998 for which

Benefits are described under *Reconstructive Procedures* in Section 6, *Additional Coverage Details*.

## Providers

Services:

1. performed by a provider who is a family member by birth or marriage, including your Spouse, brother, sister, parent or child;

2. a provider may perform on himself or herself;

3. performed by a provider with your same legal residence;

4. ordered or delivered by a Christian Science practitioner;

5. performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license;

6. provided at a diagnostic facility (Hospital or free-standing) without a written order from a provider;

7. which are self-directed to a free-standing or Hospital-based diagnostic facility; and

8. ordered by a provider affiliated with a diagnostic facility (Hospital or free-standing), when that provider is not actively involved in your medical care:

   - prior to ordering the service; or
   - after the service is received.

   This exclusion does not apply to mammography testing.

## Reproduction

1. health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment;

   This exclusion does not apply to services required to treat or correct underlying causes of infertility.

2. storage and retrieval of all reproductive materials (examples include eggs, sperm, testicular tissue and ovarian tissue);

3. surrogate parenting, donor eggs, donor sperm and host uterus;

4. the reversal of voluntary sterilization;

5. artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes;

6. fetal reduction surgery;

7. elective surgical, non-surgical or drug induced Pregnancy termination;

   This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage). Furthermore, this exclusion does not apply with respect to, and the Plan will provide coverage for, the following: (i) an abortion where the life of the mother would be endangered if the fetus were carried to term, and (ii) medical complications that arise from an abortion.

8. contraceptive supplies and services (other than those covered under Preventive Care Services in Section 6, *Additional Coverage Details*);

9. services provided by a doula (labor aide); and

10. parenting, pre-natal or birthing classes.

### Services Provided under Another Plan

Services for which coverage is available:

1. under another plan, except for Eligible Expenses payable as described in Section 10, *Coordination of Benefits (COB)*;

2. under workers' compensation, no-fault automobile coverage or similar legislation if you could elect it, or could have it elected for you;

3. while on active military duty; and

4. for treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably accessible.

### Transplants

1. health services for organ and tissue transplants, except as identified under *Transplantation Services* in Section 6, *Additional Coverage Details* unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines;

2. mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available); and

3. donor costs for organ or tissue transplantation to another person (these costs may be payable through the recipient's benefit plan).

### Travel

1. health services provided in a foreign country, unless required as Emergency Health Services; and

2. travel or transportation expenses, even if ordered by a Physician, except as identified under *Travel and Lodging* in Section 6, *Additional Coverage Details*. Additional travel

expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at the Plan's discretion.

## Types of Care

1. Custodial Care as defined in Section 14, *Glossary* or maintenance care;

2. Domiciliary Care, as defined in Section 14, *Glossary;*

3. multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain;

4. Private Duty Nursing received on an inpatient basis;

5. respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are described under *Hospice Care* in Section 6, *Additional Coverage Details*;

6. rest cures;

7. services of personal care attendants; and

8. work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

## Vision and Hearing

1. implantable lenses used only to correct a refractive error (such as Intacs corneal implants);

2. purchase cost and associated fitting charges for eyeglasses or contact lenses;

3. bone anchored hearing aids except when either of the following applies:

   - for Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or
   - for Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

   The Plan will not pay for more than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled in this Plan. In addition, repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage are not covered, other than for malfunctions.

4. eye exercise or vision therapy; and

5. surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.

## All Other Exclusions

1. autopsies and other coroner services and transportation services for a corpse;

2. charges for:

   - missed appointments;
   - room or facility reservations;
   - completion of claim forms; or
   - record processing.

3. charges prohibited by federal anti-kickback or self-referral statutes;

4. diagnostic tests that are:

   - delivered in other than a Physician's office or health care facility; and
   - self-administered home diagnostic tests, including but not limited to HIV and Pregnancy tests.

5. expenses for health services and supplies:

   - that do not meet the definition of a Covered Health Service in Section 14, *Glossary*;
   - that are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone;
   - that are received after the date your coverage under this Plan ends, including health services for medical conditions which began before the date your coverage under the Plan ends;
   - for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Benefit Plan; or
   - that exceed Eligible Expenses or any specified limitation in this SPD;
   - for which a non-Network provider waives the Copay, Annual Deductible or Coinsurance amounts.

6. foreign language and sign language services;

7. long term (more than 30 days) storage of blood, umbilical cord or other material. Examples include cryopreservation of tissue, blood and blood products; and

8. physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:

   - required solely for purposes of education, sports or camp, travel, career or employment, insurance, marriage or adoption; or as a result of incarceration;

- conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 6, *Additional Coverage Details*;
- related to judicial or administrative proceedings or orders; or
- required to obtain or maintain a license of any type.

# SECTION 9 - CLAIMS PROCEDURES

**What this section includes:**

- How Network and non-Network claims work; and
- What to do if your claim is denied, in whole or in part.

## Network Benefits

In general, if you receive Covered Health Services from a Network provider, UnitedHealthcare will pay the Physician or facility directly. If a Network provider bills you for any Covered Health Service other than your Coinsurance, please contact the provider or call UnitedHealthcare at the phone number on your ID card for assistance.

Keep in mind, you are responsible for meeting the Annual Deductible and paying any Coinsurance owed to a Network provider at the time of service, or when you receive a bill from the provider.

## Non-Network Benefits

If you receive a bill for Covered Health Services from a non-Network provider, you (or the provider if they prefer) must send the bill to UnitedHealthcare for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to UnitedHealthcare at the address on the back of your ID card.

## Prescription Drug Benefit Claims

If you wish to receive reimbursement for a prescription, you may submit a post-service claim as described in this section if:

- you are asked to pay the full cost of the Prescription Drug Product when you fill it and you believe that the Plan should have paid for it; or
- you pay a Coinsurance and you believe that the amount of the Coinsurance was incorrect.

If a pharmacy (retail or mail order) fails to fill a prescription that you have presented and you believe that it is a Covered Health Service, you may submit a pre-service request for Benefits as described in this section.

## If Your Provider Does Not File Your Claim

You can obtain a claim form by visiting **www.myuhc.com**, calling the toll-free number on your ID card or contacting Human Resources. If you do not have a claim form, simply attach a brief letter of explanation to the bill, and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

- your name and address;
- the patient's name, age and relationship to the Participant;

- the number as shown on your ID card;
- the name, address and tax identification number of the provider of the service(s);
- a diagnosis from the Physician;
- the date of service;
- an itemized bill from the provider that includes:
  - the Current Procedural Terminology (CPT) codes;
  - a description of, and the charge for, each service;
  - the date the Sickness or Injury began; and
  - a statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name and address of the other carrier(s).

Failure to provide all the information listed above may delay any reimbursement that may be due you.

For medical claims, the above information should be filed with UnitedHealthcare at the address on your ID card. When filing a claim for outpatient Prescription Drug Product Benefits, submit your claim to the pharmacy benefit manager claims address noted on your ID card.

After UnitedHealthcare has processed your claim, you will receive payment for Benefits that the Plan allows. It is your responsibility to pay the non-Network provider the charges you incurred, including any difference between what you were billed and what the Plan paid.

If UnitedHealthcare sends a reimbursement directly to you (the Participant) it is your responsibility to reimburse the non-Network provider upon receipt of their bill. UnitedHealthcare reserves the right, in its discretion, to pay the non-Network provider directly for services rendered to you, even if you have assigned your rights to the provider to receive payments directly. When exercising its discretion with respect to the payment of claims to non-Network providers, UnitedHealthcare may consider whether you (the Participant) has requested that payment of your Benefits be made directly to the non-Network provider. Under no circumstances, however, will UnitedHealthcare pay Benefits to anyone other than you or, in its discretion, your provider. Direct payment to a non-Network provider shall not be deemed to constitute consent by UnitedHealthcare to an assignment or to waive the consent requirement. When UnitedHealthcare in its discretion directs payment to a non-Network provider, you remain the sole beneficiary of the payment, and the non-Network provider does not thereby become a beneficiary. Accordingly, legally required notices concerning your Benefits will be directed to you, although UnitedHealthcare may in its discretion send information concerning the Benefits to the non-Network provider as well. If payment to a non-Network provider is made, the Plan reserves the right to offset Benefits to be paid to the provider by any amounts that the provider owes the Plan, pursuant to *Refund of Overpayments* in Section 10, *Coordination of Benefits*.

## Health Statements

Each month in which UnitedHealthcare processes at least one claim for you or a covered Dependent, you will receive a Health Statement in the mail. Health Statements make it easy for you to manage your family's medical costs by providing claims information in easy-to-understand terms.

If you would rather track claims for yourself and your covered Dependents online, you may do so at **www.myuhc.com**. You may also elect to discontinue receipt of paper Health Statements by making the appropriate selection on this site.

## Explanation of Benefits (EOB)

You may request that UnitedHealthcare send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. If you would like paper copies of the EOBs, you may call the toll-free number on your ID card to request them. You can also view and print all of your EOBs online at **www.myuhc.com**. See Section 14, *Glossary* for the definition of Explanation of Benefits.

**Important - Timely Filing of Non-Network Claims**
All claim forms for non-Network services must be submitted within 12 months after the date of service. Otherwise, the Plan will not pay any Benefits for that Eligible Expense, or Benefits will be reduced, as determined by Lockton, Inc. This 12-month requirement does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

## Claim Denials and Appeals

### *If a Claim is Denied*

If a claim for Benefits is denied in part or in whole, a claimant may call UnitedHealthcare at the number on his or her ID card before requesting a formal appeal. If UnitedHealthcare cannot resolve the issue to the claimant's satisfaction over the phone, the claimant has the right to file a formal appeal as described below.

### *Manner and Content of Notification of Benefit Determination*

UnitedHealthcare will provide a claimant with written or electronic notification of any adverse benefit determination in a culturally and linguistically appropriate manner. The notification will set forth the following information:

(i) information sufficient to identify the claim, including all information as required by federal law;

(ii) the specific reason or reasons for the adverse determination, including the denial code and its corresponding meaning, as well as a description of the standard, if any, that was used in denying the claim;

(iii) reference to the specific Plan provisions on which the determination is based;

(iv) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

(v) a description of the Plan's review procedures, both internal and external, and the time limits applicable to such procedures, including information regarding how to initiate a review of the claim denial. This explanation will include a statement of the claimant's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review;

(vi) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either (i) the specific rule, guideline, protocol, or other similar criterion, or (ii) a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request;

(vii) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either (i) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or (ii) a statement that such explanation will be provided free of charge upon request;

(viii) in the case of an adverse benefit determination concerning an urgent care request for benefits, a description of the expedited review process applicable to such claims; and

(ix) the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman under federal law to assist individuals with the internal claims and appeals and external review processes.

In the case of an adverse benefit determination concerning an urgent care request for Benefits, the information described above may be provided to the claimant orally within the appropriate time frame prescribed for notification of the benefit determination, provided that a written or electronic notification is furnished to the claimant no later than three (3) days after the oral notification.

### *How to Internally Appeal a Denied Claim*

If a claimant wishes to appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described in Section 12 below, the claimant must submit the appeal in writing within 180 days of receiving the adverse benefit determination. A claimant does not need to submit urgent care appeals in writing. This communication should include:

- the patient's name and ID number as shown on the ID card;
- the provider's name;
- the date of medical service;
- the reason the claimant disagrees with the denial; and
- any documentation or other written information to support the request.

The claimant may send a written request for an appeal to:

UnitedHealthcare - Appeals
P.O. Box 30432
Salt Lake City, Utah 84130-0432

For urgent care requests for Benefits that have been denied, the claimant can call UnitedHealthcare at the toll-free number on his or her ID card to request an appeal.

**Types of claims**
The timing of the claims appeal process is based on the type of claim the claimant is appealing. If a claimant wishes to appeal a claim, it helps to understand whether it is an:

- urgent care request for Benefits;
- pre-service request for Benefits;
- post-service claim; or
- concurrent claim.

***Internal Review of an Appeal***

The claim review process will provide a claimant with a full and fair review of the claim. A claimant's coverage will continue pending the outcome of the claimant's request for review of an adverse benefit determination. As part of the review process, each claimant shall be provided the following:

(i) the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

(ii) upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;

(iii) a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;

(iv) a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

(v) that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult

with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(vi) the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;

(vii) that the health care professional engaged for purposes of a consultation described above shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;

(viii) in the case of an urgent care request for benefits, an expedited review process pursuant to which (i) a request for an expedited appeal of any adverse benefit determination may be submitted orally in writing by the claimant, and (ii) all necessary information, including the benefit determination on review, shall be transmitted between the Plan and the claimant by telephone, facsimile, or other available similarly expeditious method; and

(ix) any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim. This evidence will be provided free of charge. It will be provided as soon as possible, and sufficiently in advance of the deadline for the Plan making a decision on appeal to give the claimant a reasonable opportunity to respond prior to that date. Before issuing any adverse decision on appeal based on a new or additional rationale, the claimant will be provided, free of charge, with that rationale. The rationale will be provided as soon as possible and sufficiently in advance of the deadline for making a decision on appeal to give the claimant a reasonable opportunity to respond prior to that deadline.

***Filing a Second Internal Appeal***

The Plan offers two levels of appeal. If a claimant is not satisfied with the first level appeal decision, he or she has the right to request a second level appeal from Lockton, Inc. within 60 days from receipt of the first level appeal determination. Lockton, Inc. must notify the claimant of the appeal determination within 15 days after receiving the completed appeal for a pre-service denial and 30 days after receiving the completed post-service appeal.

The claimant may send a written request for a second level appeal to:

Benefits Administration Committee c/o Associate Benefits
Lockton, Inc.
444 W. 47th Street
Suite 900
Kansas City, MO 64112

***Note:*** Lockton, Inc. will review all claims in accordance with the rules established by the U.S. Department of Labor. Lockton, Inc.'s decision will be final.

***Manner and Content of Notification of Benefit Determination on Review***

The claimant will be provided with written or electronic notification of the benefit determination on review in a culturally and linguistically appropriate manner. In the case of an adverse benefit determination, the notification shall set forth, in a manner calculated to be understood by the claimant:

(i) information sufficient to identify the claim, including all information as required by federal law;

(ii) the specific reason or reasons for the adverse determination, including the denial code and its corresponding meaning, as well as a description of the standard, if any, that was used in denying the claim. This description will include a discussion of the decision;

(iii) reference to the specific Plan provisions on which the benefit determination is based;

(iv) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claimant's claim for benefits;

(v) a statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to obtain the information about such procedures, as well as a description of the available external review procedures, including information regarding how to initiate an external review of the claim denial, and the time limits applicable to the Plan's external claims review procedures. This explanation will include a statement of the claimant's right to bring an action under section 502(a) of ERISA;

(vi) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either (i) the specific rule, guideline, protocol, or other similar criterion, or (ii) a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request;

(vii) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either (i) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or (ii) a statement that such explanation will be provided free of charge upon request; and

(viii) the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman under federal law to assist individuals with the internal claim, internal appeal, and external review processes.

In the case of an adverse benefit determination on review, a claimant will be provided access to, and copies of, documents, records, and other information described in items (iv) through (viii) above as is appropriate. A document, record or other information shall be considered "relevant" to a claimant's claim if such document, record or other information (i) was relied upon in making the benefit determination, (ii) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination, (iii) demonstrates compliance with the administrative processes and safeguards required by law in making the benefit determination, or (iv) constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

***Timing of Notification of Benefit Determinations and Timing of Notification of Appeals Determinations***

Separate schedules apply to the timing of claims appeals, depending on the type of claim. There are three types of claims:

- Urgent care request for Benefits – an urgent care request for Benefits is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations (A) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or (B) in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Whether a claim is an urgent care request for Benefits within the meaning of subdivision (A) in the preceding sentence is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Note, however, that any claim that a physician with knowledge of a claimant's medical condition determines is an urgent care request for Benefits shall be treated as such an urgent care request for Benefits;
- Pre-service request for Benefits - a pre-service request for Benefits is any claim for a benefit with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care; and
- Post-service request for Benefits – a post-service request for Benefits is any claim for a benefit that is not a pre-service claim for Benefits.

The tables below describe the time frames which a claimant and UnitedHealthcare are required to follow.

| **Urgent Care Request for Benefits*** | |
|---|---|
| **Type of Request for Benefits or Appeal** | **Timing**** |
| If a claimant's request for Benefits is incomplete, UnitedHealthcare must notify the claimant: | As soon as possible, but not later than **24 hours** |

| Urgent Care Request for Benefits* | |
|---|---|
| **Type of Request for Benefits or Appeal** | **Timing**** |
| The claimant must then provide completed request for Benefits to UnitedHealthcare within: | **48 hours** after receiving notice of additional information required*** |
| UnitedHealthcare must notify the claimant of the benefit determination (whether adverse or not): | As soon as possible, taking into account the medical exigencies, but not later than **72 hours** |
| If UnitedHealthcare denies the request for Benefits, the claimant must appeal an adverse benefit determination no later than: | **180 days** after receiving the adverse benefit determination |
| UnitedHealthcare must notify the claimant of the appeal decision: | As soon as possible, taking into account the medical exigencies, but not later than **72 hours** after receiving the appeal |

*A claimant does not need to submit urgent care appeals in writing. The claimant should call UnitedHealthcare as soon as possible to appeal an urgent care request for Benefits.

**For purposes of these timing rules, an urgent care request for benefits has the meaning given earlier in this Section 9, as determined by the attending provider, and the Plan will defer to such determination by the attending provider.

***In this situation, UnitedHealthcare must notify the claimant of the benefit determination (whether adverse or not) as soon as possible, but in no case later than 48 hours after the earlier of (i) the receipt of the additional information required, and (ii) the end of the period afforded the claimant to provide the additional information required.

| Pre-Service Request for Benefits | |
|---|---|
| **Type of Request for Benefits or Appeal** | **Timing** |
| If a claimant's request for Benefits is filed improperly, UnitedHealthcare must notify the claimant within: | **5 days** |
| If the claimant's request for Benefits is incomplete, UnitedHealthcare must notify the claimant within: | **15 days** |
| The claimant must then provide completed request for Benefits information to UnitedHealthcare within: | **45 days** |
| UnitedHealthcare must notify the claimant of the benefit determination (whether adverse or not): | |

| Pre-Service Request for Benefits | |
|---|---|
| **Type of Request for Benefits or Appeal** | **Timing** |
| ■ if the initial request for Benefits is complete, within: | **15 days*** |
| ■ after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within: | **15 days** |
| The claimant must appeal an adverse benefit determination no later than: | **180 days** after receiving the adverse benefit determination |
| UnitedHealthcare must notify the claimant of the first level appeal decision within: | **15 days** after receiving the first level appeal |
| The claimant must appeal the first level appeal (file a second level appeal) within: | **60 days** after receiving the first level appeal decision |
| Lockton, Inc. must notify the claimant of the second level appeal decision within: | **15 days** after receiving the second level appeal |

*UnitedHealthcare may be entitled to a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond its control.

| Post-Service Claims | |
|---|---|
| **Type of Claim or Appeal** | **Timing** |
| If a claimant's claim is incomplete, UnitedHealthcare must notify the claimant within: | **30 days** |
| The claimant must then provide completed claim information to UnitedHealthcare within: | **45 days** |
| UnitedHealthcare must notify the claimant of an adverse benefit determination: | |
| ■ if the initial claim is complete, within: | **30 days*** |
| ■ after receiving the completed claim (if the initial claim is incomplete), within: | **15 days** |
| The claimant must appeal an adverse benefit determination no later than: | **180 days** after receiving the adverse benefit determination |
| UnitedHealthcare must notify the claimant of the first level appeal decision within: | **30 days** after receiving the first level appeal |
| The claimant must appeal the first level appeal (file a second level appeal) within: | **60 days** after receiving the first level appeal decision |

| Post-Service Claims | |
|---|---|
| **Type of Claim or Appeal** | **Timing** |
| Lockton, Inc. must notify the claimant of the second level appeal decision within: | **30 days** after receiving the second level appeal |

***** UnitedHealthcare may be entitled to a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond its control.

Note that the period of time within which a benefit determination is required to be made will begin at the time a claim or appeal is filed in accordance with the provisions of the Plan, without regard to whether all the information necessary to make the benefit determination (or the benefit determination on review) accompanies the filing. In the event that a period of time is extended due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination (or benefit determination on review) shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

### *Concurrent Care Claims*

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and a claimant's request to extend the treatment is an urgent care request for Benefits as defined above, such request will be decided as soon as possible, taking into account the medical exigencies, and the claimant will be notified of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Plan, provided that any such claim is made at least 24 hours prior to the end of the approved treatment. If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and a claimant requests to extend treatment in a non-urgent circumstance, such request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, any reduction or termination by the Plan of such course of treatment (other than by plan amendment or termination) before the end of such period of time or number of treatments will constitute an adverse benefit determination. The claimant will be notified of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

### *Avoiding Conflicts of Interest*

All claims and appeals shall be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decisions. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based on the likelihood that the individual will support the denial of benefits.

## Authorized Representative

Nothing in this Section 9 precludes an authorized representative of a claimant from acting on behalf of the claimant in pursuing a benefit claim or appeal of an adverse benefit determination. The Plan may establish reasonable procedures for determining whether an individual has been authorized to act on behalf of a claimant. However, in the case of an urgent care claim for Benefits, a health care professional with knowledge of the claimant's medical condition will be permitted to act as the authorized representative of the claimant.

## Limitation of Action

A claimant cannot bring any legal action against Lockton, Inc. or the Claims Administrator to recover reimbursement until 90 days after the claimant has properly submitted a request for reimbursement as described in this section and all required reviews of the claimant's claim have been completed. If a claimant wants to bring a legal action against Lockton, Inc. or the Claims Administrator, he or she must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or the claimant loses any rights to bring such an action against Lockton, Inc. or the Claims Administrator.

A claimant cannot bring any legal action against Lockton, Inc. or the Claims Administrator for any other reason unless he or she first completes all the steps in the appeal process described in this section. After completing that process, if the claimant wants to bring a legal action against Lockton, Inc. or the Claims Administrator he or she must do so within three years of the date he or she is notified of the final decision on the appeal or the claimant loses any rights to bring such an action against Lockton, Inc. or the Claims Administrator.

## Claims Procedures Are Subject to Change

The claims procedures described in this Section 9 may, in the future, be subject to either statutory or regulatory changes. In the case of such future statutory or regulatory changes, UnitedHealthcare will utilize and follow the updated claims procedures as changed and as are required by law at that particular time, and you will be provided either with an updated SPD incorporating the updated claims procedures or a separate summary that describes the updated claims procedures.

## External Review Program

You may be able to choose to participate in the External Review Program. If you qualify for the External Review Program, you may file a request for external review by making a request for such an external review within four (4) months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. By doing so, you would be requesting review by an outside independent review organization (an "IRO"). You or an authorized designated representative may request an external review under the External Review Program by calling the toll-free number on your ID card or by sending a written request to the address on your ID card.

The External Review Program is not available where a denial, reduction, termination or failure to provide payment for a benefit is based on a determination that you fail to meet the requirements for eligibility under the terms of the Plan. In addition, with respect to claims for which an external review has not been initiated before September 20, 2011, the External Review Program applies only to:

- an adverse benefit determination (including a final internal adverse benefit determination) that involves medical judgment (including, but not limited to, those determinations based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or the Plan's determination that a treatment is experimental or investigational), as determined by the external reviewer; and
- a rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time.

Within five business days following receipt of your request for external review, a preliminary review of the request will be completed to determine whether (a) you are or were covered under the Plan at the time a health care item or service was requested or, in the case of a retrospective review, you were covered under the Plan at the time the health care item or service was provided, (b) the adverse benefit determination or final adverse benefit determination does not relate to your failure to meet the Plan's requirements for eligibility for coverage, (c) you have exhausted the Plan's internal appeals process, unless you are not required to exhaust the internal appeals process, and (d) you have provided all the information and forms required to process an external review.

Within one business day after completing this preliminary review, a notification in writing will be issued to you. If the request is complete but not eligible for external review, the notification will include the reasons for its ineligibility and contact information for the Department of Labor's Employee Benefits Security Administration (toll free number 866-444-EBSA (3272)). If the request is not complete, the notification will describe the information or materials needed to make the request complete and you will be allowed to perfect your request for external review within the four-month filing period or within the 48-hour period following the receipt of the notification, whichever is later.

An independent review organization ("IRO") will be assigned that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review.

The IRO will timely notify you in writing of the request's eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the IRO within 10 business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.

Within five business days after the date an IRO is assigned to conduct the external review, the Plan will provide to the IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. If the Plan fails to timely provide the documents and information, this will not delay the conduct of the external review, and the IRO may make a decision to reverse the adverse benefit determination or final internal adverse benefit determination. Within one business day after making this decision, the IRO will notify you and the Plan.

Upon receipt of any information submitted by you, the IRO will be required within one business day to forward that information to the Plan. Upon receipt of any such information,

the Plan may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. This reconsideration will not, however, delay the external review. The external review will be terminated as a result of the reconsideration only if the Plan decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one business day after making such a decision, the Plan will provide written notice of its decision to you and the IRO, and the IRO will terminate the external review.

Where an IRO has been assigned to conduct an external review, the IRO will review all of the information and documents it receives on a timely basis. In reaching a decision, the IRO will review the claim without being bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

1. Your medical records;

2. The attending health care professional's recommendation;

3. Reports from appropriate health care professionals and other documents submitted by the Plan, you, or your treating provider;

4. The terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless those terms are inconsistent with applicable law;

5. Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;

6. Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and

7. The opinion of the IRO's clinical reviewer or reviewers after considering the information or documents available, to the extent the clinical reviewer or reviewers consider appropriate.

The IRO will provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review. The IRO will deliver the notice to you and the Plan.

The IRO's written notification will contain the following:

1. A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);

2. The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

3. References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

4. A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

5. A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the Plan or to you;

6. A statement that judicial review may be available to you; and

7. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under federal law.

With respect to item number 5 in the immediately above list, the requirement that the decision be binding shall not preclude the Plan from making payment on the claim or otherwise providing benefits at any time, including after a final external review decision that denies the claim or otherwise fails to require such payment or benefits.

After a final external review decision, the IRO will maintain records of all claims and notices associated with the external review process for six years. An IRO will make such records available for examination by you, the Plan, or a state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

Upon receipt of a notice of a final external review decision reversing the Plan's adverse benefit determination or final internal adverse benefit determination, the Plan will immediately and without delay provide coverage or payment (including immediately and without delay authorizing or immediately and without delay paying benefits) for the claim pursuant to the final external review decision. The Plan will immediately and without delay provide such coverage or payment regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

You may make a request for an expedited external review in certain circumstances. That will be the case where you receive an adverse benefit determination if the adverse benefit determination involves a medical condition of you for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal.

You may also request an expedited external review of a final internal adverse benefit determination, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item

or service for which you received emergency services, but you have not been discharged from a facility.

If you request an expedited external review, the normal rules for external review, set forth above in this External Review Program section, will apply, except as follows:

- Immediately upon receipt of the request for expedited external review, a determination will be made as to whether the request meets the reviewability requirements described above for a standard external review. You will immediately be sent a notice of the request's eligibility for an expedited external review.
- Upon a determination that a request is eligible for external review following the preliminary review, an IRO will be assigned and all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination will be provided or transmitted to the assigned IRO electronically or by telephone or facsimile or any other available expeditious manner.
- The IRO will be required to provide notice of the final external review decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to you and the Plan.

# SECTION 10 - COORDINATION OF BENEFITS (COB)

**What this section includes:**

- How your Benefits under this Plan coordinate with other medical plans;
- How coverage is affected if you become eligible for Medicare; and
- Procedures in the event the Plan overpays Benefits.

Coordination of Benefits (COB) applies to you if you are covered by more than one health benefits plan, including any one of the following:

- another employer sponsored health benefits plan;
- a medical component of a group long-term care plan, such as skilled nursing care;
- no-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy;
- medical payment benefits under any premises liability or other types of liability coverage; or
- Medicare or other governmental health benefit.

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the primary plan.

**Don't forget to update your Dependents' Medical Coverage Information**
Avoid delays on your Dependent claims by updating your Dependent's medical coverage information. Just log on to **www.myuhc.com** or call the toll-free number on your ID card to update your COB information. You will need the name of your Dependent's other medical coverage, along with the policy number.

## Determining Which Plan is Primary

If you are covered by two or more plans, the benefit payment follows the rules below in this order:

- this Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy;
- when you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first;
- a plan that covers a person as an employee pays benefits before a plan that covers the person as a dependent;
- if you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first;

- your dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:
  - the parents are married or living together whether or not they have ever been married and not legally separated; or
  - a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage;
- if two or more plans cover a dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:
  - the parent with custody of the child; then
  - the Spouse of the parent with custody of the child; then
  - the parent not having custody of the child; then
  - the Spouse of the parent not having custody of the child.
- plans for active employees pay before plans covering laid-off or retired employees;
- the plan that has covered the individual claimant the longest will pay first; Only expenses normally paid by the Plan will be paid under COB; and
- finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the primary Plan.

The following examples illustrate how the Plan determines which plan pays first and which plan pays second.

**Determining Primary and Secondary Plan – Examples**
1) Let's say you and your Spouse both have family medical coverage through your respective employers. You are unwell and go to see a Physician. Since you're covered as a Participant under this Plan, and as a Dependent under your Spouse's plan, this Plan will pay Benefits for the Physician's office visit first.
2) Again, let's say you and your Spouse both have family medical coverage through your respective employers. You take your Dependent child to see a Physician. This Plan will look at your birthday and your Spouse's birthday to determine which plan pays first. If you were born on June 11 and your Spouse was born on May 30, your Spouse's plan will pay first.

### When This Plan is Secondary

If this Plan is secondary, it determines the amount it will pay for a Covered Health Service by following the steps below.

- the Plan determines the amount it would have paid based on the primary plan's allowable expense.

- if this Plan would have paid less than the primary plan paid, the Plan pays no Benefits.
- if this Plan would have paid more than the primary plan paid, the Plan will pay the difference.

The maximum combined payment you can receive from all plans may be less than 100% of the total allowable expense.

### *Determining the Allowable Expense When This Plan is Secondary*

When this Plan is secondary, the allowable expense is the primary plan's Network rate. If the primary plan bases its reimbursement on reasonable and customary charges, the allowable expense is the primary plan's reasonable and customary charge. If both the primary plan and this Plan do not have a contracted rate, the allowable expense will be the greater of the two plans' reasonable and customary charges.

When the provider is a Network provider for both the primary plan and this Plan, the allowable expense is the primary plan's network rate. When the provider is a network provider for the primary plan and a non-Network provider for this Plan, the allowable expense is the primary plan's network rate. When the provider is a non-Network provider for the primary plan and a Network provider for this Plan, the allowable expense is the reasonable and customary charges allowed by the primary plan. When the provider is a non-Network provider for both the primary plan and this Plan, the allowable expense is the greater of the two Plans' reasonable and customary charges.

**What is an allowable expense?**
For purposes of COB, an allowable expense is a health care expense that is covered at least in part by one of the health benefit plans covering you.

## When a Covered Person Qualifies for Medicare

### *Determining Which Plan is Primary*

To the extent permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- employees with active current employment status age 65 or older and their Spouses age 65 or older (Note: This rule does not apply to Domestic Partners as provided by Medicare); and
- individuals with end-stage renal disease, for a limited period of time.

### *Determining the Allowable Expense When This Plan is Secondary to Medicare*

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts Medicare. If the provider does not accept Medicare, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the total allowable expense.

If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, or if you have enrolled in Medicare but choose to obtain services from a provider that does not participate in the Medicare program, Benefits will be paid on a secondary basis under this Plan and will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider.

When calculating the Plan's Benefits in these situations, for administrative convenience UnitedHealthcare in its sole discretion may treat the provider's billed charges as the allowable expense for both the Plan and Medicare, rather than the Medicare approved amount or Medicare limiting charge.

## Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. UnitedHealthcare may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits.

UnitedHealthcare not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give UnitedHealthcare any facts needed to apply those rules and determine benefits payable. If you do not provide UnitedHealthcare the information needed to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

## Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that UnitedHealthcare should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Company may recover the amount in the form of salary, wages, or benefits payable under any Company-sponsored benefit plans, including this Plan. The Company also reserves the right to recover any overpayment by legal action or offset payments on future Eligible Expenses.

If the Plan overpays a health care provider, UnitedHealthcare reserves the right to recover the excess amount from the provider pursuant to *Refund of Overpayments*, below.

### *Refund of Overpayments*

If the Plan pays for Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to the Plan if:

- the Plan's obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid by the Covered Person, but all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person;

- all or some of the payment the Plan made exceeded the Benefits under the Plan; or
- all or some of the payment was made in error.

The amount that must be refunded equals the amount the Plan paid in excess of the amount that should have paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help the Plan get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits for the Covered Person that are payable under the Plan; (ii) future Benefits that are payable to other Covered Persons under the Plan; or (iii) future benefits that are payable for services provided to persons under other plans for which UnitedHealthcare makes payments, with the understanding that UnitedHealthcare will then reimburse the Plan the amount of the reallocated payment. The reallocated payment amount will equal the amount of the required refund or, if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan. The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

## TRICARE

Notwithstanding any provision of this Plan to the contrary, the following rules shall apply: (i) this Plan shall not offer any financial or other incentives for a TRICARE-eligible employee not to enroll (or to terminate enrollment) in this Plan in the situation where this Plan would (in the case of enrollment) be a primary plan, in the same manner as the provisions of the Social Security Act apply to prohibit the offering of any financial or other incentives for an individual entitled to Medicare benefits not to enroll (or to terminate enrollment) under a group health plan or large group health plan which would (in the case of enrollment) be a primary plan; and (ii) a TRICARE-eligible employee shall have the opportunity to elect to participate in this Plan and receive primary coverage for health care services under the Plan in the same manner and to the same extent as similarly-situated employees who are not TRICARE-eligible employees. For purposes of this provision, the term "TRICARE-eligible employee" means a covered beneficiary under 10 U.S.C. Section 1097c(f)(3) who is entitled to health care benefits under the TRICARE program.

## SECTION 11 - SUBROGATION AND REIMBURSEMENT

The Plan has a right to subrogation and reimbursement.

Subrogation applies when the plan has paid Benefits on your behalf for a Sickness or Injury for which a third party is alleged to be responsible. The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the Benefits that the Plan has paid that are related to the Sickness or Injury for which a third party is alleged to be responsible.

***Subrogation – Example***
Suppose you are injured in a car accident that is not your fault, and you receive Benefits under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those Benefits.

The right to reimbursement means that if a third party causes or is alleged to have caused a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any Benefits you received for that Sickness or Injury.

***Reimbursement – Example***
Suppose you are injured in a boating accident that is not your fault, and you receive Benefits under the Plan as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the plan 100% of any Benefits you received to treat your injuries.

The following persons and entities are considered third parties:

- a person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages;
- any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages;
- the Plan Sponsor (for example workers' compensation cases);
- any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators; and
- any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable;
  - providing any relevant information requested by the Plan;
  - signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim;
  - responding to requests for information about any accident or injuries;
  - making court appearances;
  - obtaining the Plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses; and
  - complying with the terms of this section.

  Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.
- The Plan has a first priority right to receive payment over you or any other party on any claim against a third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to Hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including court costs or attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-

Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.

- Benefits paid by the Plan may also be considered to be Benefits advanced.
- If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you shall hold those funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the Benefits the Plan has paid.
- The Plan's rights to recovery will not be reduced due to your own negligence.
- Upon the Plan's request, you will assign to the Plan all rights of recovery against third parties, to the extent of the Benefits the Plan has paid for the Sickness or Injury.
- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party and filing suit in your name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If a third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.
- The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

## Right of Recovery

The Plan has the right to recover benefits it has paid on you or your Dependent's behalf that were:

- made in error;
- due to a mistake in fact;
- advanced during the time period of meeting the calendar year Deductible; or
- advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.

Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

If the Plan provides a Benefit for you or your Dependent that exceeds the amount that should have been paid, the Plan will:

- require that the overpayment be returned when requested, or
- reduce a future benefit payment for you or your Dependent by the amount of the overpayment.

If the Plan provides an advancement of benefits to you or your Dependent during the time period of meeting the Deductible and/or meeting the Out-of-Pocket Maximum for the calendar year, the Plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover Benefits it has advanced by:

- submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan; and
- conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

## SECTION 12 - WHEN COVERAGE ENDS

**What this section includes:**

- Circumstances that cause coverage to end;
- Extended coverage; and
- How to continue coverage after it ends.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date. Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.

When your coverage ends, Lockton, Inc. will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, Benefits are not provided for health services that you receive after coverage ended, even if the underlying medical condition occurred before your coverage ended. Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.

Your coverage under the Plan will end on the earliest of:

- the date your employment with the Company ends;
- the date the Plan ends;
- the date you stop making the required contributions;
- the date you are no longer eligible;
- the date UnitedHealthcare receives written notice from Lockton, Inc. to end your coverage, or the date requested in the notice, if later; or
- the date you retire or are pensioned under the Plan, unless specific coverage is available for retired or pensioned persons and you are eligible for that coverage.

Coverage for your eligible Dependents will end on the earliest of:

- the date your coverage ends;
- the date you stop making the required contributions;
- the date UnitedHealthcare receives written notice from Lockton, Inc. to end your coverage, or the date requested in the notice, if later;
- the last day of the month your Dependent child no longer qualifies as a Dependent under this Plan; or
- the date your Dependent Spouse no longer qualifies as a Dependent under this Plan.

### *Other Events Ending Your Coverage*

The Plan will provide prior written notice to you that your coverage will end on the date identified in the notice if:

- you commit an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact including, but not limited to, knowingly providing incorrect information relating to another person's eligibility or status as a Dependent; or

***Note***: If UnitedHealthcare and Lockton, Inc. find that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact Lockton, Inc. has the right that you pay back all Benefits Lockton, Inc. paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.

## Rescission of Coverage

Notwithstanding any other provision of this Plan to the contrary, the Plan may rescind (that is, cancel or discontinue coverage with a retroactive effect) your coverage or your Dependent's coverage once you or your Dependent become covered under the Plan, but only if you or your Dependent (a) perform(s) an act, practice or omission that constitutes fraud, or (b) make(s) an intentional misrepresentation of material fact. In the event that coverage will be rescinded, the individual(s) who would be affected by the rescission will be provided at least 30 days advance written notice of the rescission. If the conduct resulting in the rescission of coverage was committed only by your Dependent, your coverage will not be rescinded (though your Dependent's coverage may be rescinded). If the conduct was committed by you, the coverage of both you and your Dependent(s) may be rescinded.

## Coverage for a Disabled Child

If an unmarried enrolled Dependent child with a mental or physical disability reaches an age when coverage would otherwise end, the Plan will continue to cover the child, as long as:

- the child is unable to be self-supporting due to a mental or physical handicap or disability;
- the child depends mainly on you for support;
- you provide to Lockton, Inc. proof of the child's incapacity and dependency within 31 days of the date coverage would have otherwise ended because the child reached a certain age; and
- you provide proof, upon Lockton, Inc.'s request, that the child continues to meet these conditions.

The proof might include medical examinations at Lockton, Inc.'s expense. However, you will not be asked for this information more than once a year. If you do not supply such proof within 31 days, the Plan will no longer pay Benefits for that child.

Coverage will continue, as long as the enrolled Dependent is incapacitated and dependent upon you, unless coverage is otherwise terminated in accordance with the terms of the Plan.

## Extended Coverage for Total Disability

If a Covered Person has a Total Disability on the date their coverage under the Plan ends, their Benefits will not end automatically. The Plan will temporarily extend coverage, only for treatment of the condition causing the Total Disability.

Benefits will be paid until the earlier of:

- the Total Disability ends; or
- 6 months from the date coverage would have ended.

## Continuing Coverage Through COBRA

If you lose your Plan coverage, you may have the right to extend it for a limited period of time under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as defined in Section 14, *Glossary*.

Continuation coverage under COBRA is available only to group health plans that are subject to the terms of COBRA. You can contact your Plan Administrator to determine if the Plan is subject to the provisions of COBRA.

### *Continuation Coverage under Federal Law (COBRA)*

Much of the language in this section comes from the federal law that governs continuation coverage. You should call your Plan Administrator if you have questions about your right to continue coverage.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary." A Qualified Beneficiary is any of the following persons who were covered under the Plan on the day before a qualifying event:

- a Participant;
- a Participant's enrolled Spouse or Dependent children, including with respect to the Participant's children, a child born to or placed for adoption with the Participant during a period of continuation coverage under federal law; or
- a Participant's former Spouse.

### *Qualifying Events for Continuation Coverage under COBRA*

The following table outlines situations in which you may elect to continue coverage under COBRA for yourself and your eligible Dependents, and the maximum length of time you can receive continued coverage. These situations are considered qualifying events.

| If Coverage Ends Because of the Following Qualifying Events: | You May Elect COBRA: | | |
|---|---|---|---|
| | For Yourself | For Your Spouse* | For Your Child(ren) |
| Your work hours are reduced | 18 months | 18 months | 18 months |
| Your employment terminates for any reason (other than gross misconduct) | 18 months | 18 months | 18 months |

| If Coverage Ends Because of the Following Qualifying Events: | You May Elect COBRA: | | |
|---|---|---|---|
| | For Yourself | For Your Spouse* | For Your Child(ren) |
| You or your family member become eligible for Social Security disability benefits at any time within the first 60 days of losing coverage[1] | 29 months | 29 months | 29 months |
| You die | N/A | 36 months | 36 months |
| You divorce (or legally separate) | N/A | 36 months | 36 months |
| Your child is no longer an eligible family member (e.g., reaches the maximum age limit) | N/A | N/A | 36 months |
| You become entitled to Medicare | N/A | 36 months | 36 months |
| Lockton, Inc. files for bankruptcy under Title 11, United States Code.[2] | Death | 36 months[3] | 36 months[3] |

[1]Subject to the following conditions: (i) notice of the disability must be provided within the latest of 60 days after a). the determination of the disability, b). the date of the qualifying event, c). the date the Qualified Beneficiary would lose coverage under the Plan, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase (up to 150% of the premium) in the required premium for the additional 11 months over the original 18 months; and (iii) if the Qualified Beneficiary entitled to the 11 months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

[2]This is a qualifying event for any retired Participant and his or her eligible Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

[3]From the date of the Participant's death if the Participant dies during the continuation coverage.

With respect to qualified beneficiaries other than you, and to the extent that you were entitled to Medicare prior to the qualifying event, the continuation period is thirty-six months from the date of your Medicare entitlement, if your termination of employment or your work hours being reduced occurs less than 18 months after the date you become entitled to Medicare.

With respect to qualified beneficiaries other than you, the continuation period is thirty-six months from the date of your termination of employment or your work hours being reduced (first qualifying event) if a second qualifying event that has a thirty-six month maximum coverage period occurs within the original 18-month period.

*Note that a Domestic Partner is not a qualified beneficiary eligible for COBRA continuation coverage under federal law. If, however, you are in a domestic partnership and you experience a COBRA qualifying event that is a reduction in work hours or a termination of employment you will be able to elect COBRA coverage that is identical to the coverage that was in effect the day before the qualifying event, including domestic partner coverage.

### *Getting Started*

You will be notified by mail if you become eligible for COBRA coverage as a result of a reduction in work hours or termination of employment. The notification will give you instructions for electing COBRA coverage, and advise you of the monthly cost.

Your monthly cost is the full cost, including both Participant and Employer costs, plus a 2% administrative fee or other cost as permitted by law.

COBRA coverage must be elected within 60 days after the date coverage would otherwise terminate under the Plan or, if later, within 60 days after the date the election notice is provided to the qualified beneficiary by the Plan Administrator. A qualified beneficiary's initial premium due to the Plan Administrator must be paid on or before the 45th day after electing continuation coverage. Thereafter, the qualified beneficiary will have a grace period of 30 days from each monthly due date to pay his or her premium.

During the 60-day election period, the Plan will, only in response to a request from a provider, inform that provider of your right to elect COBRA coverage, retroactive to the date your COBRA eligibility began.

While you are a participant in the medical Plan under COBRA, you have the right to change your coverage election:

- during Open Enrollment; and
- following a change in family status, as described under *Changing Your Coverage* in Section 2, *Introduction*.

### *Notification Requirements*

You or a qualified beneficiary must notify the Plan Administrator of: (i) a qualifying event that is a divorce, legal separation or a Dependent child ceasing to be a Dependent under the terms of the Plan; (ii) a second qualifying event which may extend coverage; (iii) a disability determination that entitles qualified beneficiaries to an 11-month extension (from 18 months to 29 months); and (iv) a determination that a qualified beneficiary is no longer disabled.

The deadlines for providing notice of the above events are as follows:

1. In the case of notification of a qualifying event that is a divorce, legal separation or a Dependent child ceasing to be a Dependent under the terms of the Plan, notice must be

given within 60 days after the later of (i) the date on which the qualifying event occurs, or (ii) the date on which the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the qualifying event;

2. In the case of notification of a second qualifying event, notice must be given within 60 days after the later of (i) the date on which the qualifying event occurs, or (ii) the date on which the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the qualifying event;

3. In the case of notification of a disability determination, notice must be given within the timeframes described in the subsection above entitled "Qualifying Events for Continuation Coverage under COBRA;" and

4. In the case of notification of a determination that a qualified beneficiary is no longer disabled, notice must be given within 30 days after the date of the final determination that the qualified beneficiary is no longer disabled.

If you or a qualified beneficiary fail(s) to notify the Plan Administrator of any divorce, legal separation or child losing Dependent status within the 60-day period described above, the Plan Administrator is not obligated to provide continued coverage to the affected qualified beneficiary.

The above notice requirements will be satisfied by providing written notice to the Plan Administrator at the address stated in this SPD. The contents of the notice must be such that the Plan Administrator is able to determine the covered employee and qualified beneficiary or beneficiaries, the qualifying event or disability, and the date on which the qualifying event (if any) occurred.

***Trade Act of 2002***

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain Participants who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These Participants are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If a Participant qualifies or may qualify for assistance under the Trade Act of 1974, he or she should contact the Plan Administrator for additional information. The Participant must contact the Plan Administrator promptly after qualifying for assistance under the Trade Act of 1974 or the Participant will lose his or her special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that Plan coverage was lost, but begins on the first day of the special second election period.

## When COBRA Ends

COBRA coverage will end, before the maximum continuation period on the earliest of the following dates:

- the date, after electing continuation coverage, that coverage is first obtained under any other group health plan;
- the date, after electing continuation coverage, that you or your covered Dependent first becomes entitled to Medicare;
- the date coverage ends for failure to make the first required premium (premium is not paid within 45 days);
- the date coverage ends for failure to make any other monthly premium (premium is not paid within 30 days of its due date);
- the date the entire Plan ends; or
- the date coverage would otherwise terminate under the Plan as described in the beginning of this section.

***Note***: If you selected continuation coverage under a prior plan which was then replaced by coverage under this Plan, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed in this section, whichever is earlier.

## Uniformed Services Employment and Reemployment Rights Act

A Participant who leaves work to enter the services of the armed forces of the United States or certain other uniformed services may have certain rights under the terms of a Federal law – the Uniformed Services Employment and Reemployment Rights Act (USERRA). Under USERRA, you may have the right to continue coverage for yourself and your Dependents by making contributions during your service, and to have coverage reinstated upon your return. Contact the Plan Administrator for more information if you think USERRA may apply to you.

## Family and Medical Leave Act

If you take FMLA leave, the Employer will continue to maintain your coverage under the Plan to the extent required by the FMLA (that is, the Employer will continue to pay its share of the premiums to the extent that you opt to continue coverage). If your coverage ceases during the FMLA leave (for example, because you opted not to continue coverage or due to nonpayment of your share of the premiums), you may resume your coverage upon return from FMLA leave on the same terms as before the leave was taken, or as otherwise required by the FMLA. Contact the Plan Administrator for more information about these special FMLA rules.

# SECTION 13 - OTHER IMPORTANT INFORMATION

**What this section includes:**

- Court-ordered Benefits for Dependent children;
- Your relationship with UnitedHealthcare and Lockton, Inc.;
- Relationships with providers;
- Interpretation of Benefits;
- Information and records;
- Incentives to providers and you;
- The future of the Plan; and
- How to access the official Plan documents.

## Qualified Medical Child Support Orders (QMCSOs)

A qualified medical child support order (QMCSO) is a judgment, decree or order issued by a court or appropriate state agency that requires a child to be covered for medical benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement.

If the Plan receives a medical child support order for your child that instructs the Plan to cover the child, the Plan Administrator will review it to determine if it meets the requirements for a QMCSO. If it determines that it does, your child will be enrolled in the Plan as your Dependent, and the Plan will be required to pay Benefits as directed by the order.

You may obtain, without charge, a copy of the procedures governing QMCSOs from the Plan Administrator.

***Note:*** A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

## Your Relationship with UnitedHealthcare and Lockton, Inc.

In order to make choices about your health care coverage and treatment, Lockton, Inc. believes that it is important for you to understand how UnitedHealthcare interacts with the Plan Sponsor's benefit Plan and how it may affect you. UnitedHealthcare helps administer the Plan Sponsor's benefit plan in which you are enrolled. UnitedHealthcare does not provide medical services or make treatment decisions. This means:

- Lockton, Inc. and UnitedHealthcare do not decide what care you need or will receive. You and your Physician make those decisions;
- UnitedHealthcare communicates to you decisions about whether the Plan will cover or pay for the health care that you may receive (the Plan pays for Covered Health Services, which are more fully described in this SPD); and

- the Plan may not pay for all treatments you or your Physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

Lockton, Inc. and UnitedHealthcare may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. Lockton, Inc. and UnitedHealthcare will use individually identifiable information about you as permitted or required by law, including in our operations and in our research. Lockton, Inc. and UnitedHealthcare will use de-identified data for commercial purposes including research.

## Relationship with Providers

The relationships between Lockton, Inc., UnitedHealthcare and Network providers are solely contractual relationships between independent contractors. Network providers are not Lockton, Inc.'s agents or employees, nor are they agents or employees of UnitedHealthcare. Lockton, Inc. and any of its employees are not agents or employees of Network providers, nor are UnitedHealthcare and any of its employees agents or employees of Network providers.

Lockton, Inc. and UnitedHealthcare do not provide health care services or supplies, nor do they practice medicine. Instead, Lockton, Inc. and UnitedHealthcare arrange for health care providers to participate in a Network and pay Benefits. Network providers are independent practitioners who run their own offices and facilities. UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not Lockton, Inc.'s employees nor are they employees of UnitedHealthcare. Lockton, Inc. and UnitedHealthcare do not have any other relationship with Network providers such as principal-agent or joint venture. Lockton, Inc. and UnitedHealthcare are not liable for any act or omission of any provider.

UnitedHealthcare is not considered to be an employer of the Plan Administrator for any purpose with respect to the administration or provision of benefits under this Plan.

Lockton, Inc. is solely responsible for:

- enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage);
- the timely payment of Benefits; and
- notifying you of the termination or modifications to the Plan.

## Your Relationship with Providers

The relationship between you and any provider is that of provider and patient. Your provider is solely responsible for the quality of the services provided to you. You:

- are responsible for choosing your own provider;
- are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Coinsurance, any Annual Deductible and any amount that exceeds Eligible Expenses;

- are responsible for paying, directly to your provider, the cost of any non-Covered Health Service;
- must decide if any provider treating you is right for you (this includes Network providers you choose and providers to whom you have been referred); and
- must decide with your provider what care you should receive.

## Interpretation of Benefits

Lockton, Inc. and UnitedHealthcare have the sole and exclusive discretion to:

- interpret Benefits under the Plan;
- interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD and any Riders and/or Amendments; and
- make factual determinations related to the Plan and its Benefits.

Lockton, Inc. and UnitedHealthcare may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan.

In certain circumstances, for purposes of overall cost savings or efficiency, Lockton, Inc. may, in its discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that Lockton, Inc. does so in any particular case shall not in any way be deemed to require Lockton, Inc. to do so in other similar cases.

## Information and Records

Lockton, Inc. and UnitedHealthcare may use your individually identifiable health information to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. Lockton, Inc. and UnitedHealthcare may request additional information from you to decide your claim for Benefits. Lockton, Inc. and UnitedHealthcare will keep this information confidential. Lockton, Inc. and UnitedHealthcare may also use your de-identified data for commercial purposes, including research, as permitted by law.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish Lockton, Inc. and UnitedHealthcare with all information or copies of records relating to the services provided to you. Lockton, Inc. and UnitedHealthcare have the right to request this information at any reasonable time. This applies to all Covered Persons, including enrolled Dependents whether or not they have signed the Participant's enrollment form. Lockton, Inc. and UnitedHealthcare agree that such information and records will be considered confidential.

Lockton, Inc. and UnitedHealthcare have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as Lockton, Inc. is required to do by law or regulation. During and after the term of the Plan, Lockton, Inc. and UnitedHealthcare and its related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your medical records or billing statements Lockton, Inc. recommends that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from UnitedHealthcare, they also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, Lockton, Inc. and UnitedHealthcare will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. UnitedHealthcare's designees have the same rights to this information as does the Plan Administrator.

## Incentives to Providers

Network providers may be provided financial incentives by UnitedHealthcare to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness; or
- a practice called capitation which is when a group of Network providers receives a monthly payment from UnitedHealthcare for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

If you have any questions regarding financial incentives you may contact the telephone number on your ID card. You can ask whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed. In addition, you may choose to discuss these financial incentives with your Network provider.

## Incentives to You

Sometimes you may be offered coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but Lockton, Inc. recommends that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. You may call the number on the back of your ID card if you have any questions.

## Rebates and Other Payments

Lockton, Inc. and UnitedHealthcare may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet your Annual Deductible. Lockton, Inc. and UnitedHealthcare do not pass these rebates on to you, nor are

they applied to your Annual Deductible or taken into account in determining your Copays or Coinsurance.

## Workers' Compensation Not Affected

Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

## Future of the Plan

Although the Company intends to continue the Plan indefinitely, the Company does not promise the continuation of any benefits provided under the Plan, nor does it promise any specific level of benefits to employees. As a result, the Company has the right to amend or terminate the Plan at any time. The Plan may be amended or terminated by a written instrument duly adopted by the Company (or by any delegate to whom the power to amend has been properly delegated pursuant to the next sentence). The Company may delegate to one or more persons or entities the authority to amend or terminate the Plan, provided such delegation is evidenced in writing and signed by an authorized representative of the Company.

## Plan Document

This Summary Plan Description (SPD) represents an overview of your Benefits. In the event there is a discrepancy between the SPD and the official plan document, the plan document will govern. A copy of the plan document is available for your inspection during regular business hours in the office of the Plan Administrator. You (or your personal representative) may obtain a copy of this document by written request to the Plan Administrator, for a nominal charge.

## Lockton, Inc. Welfare Benefit Plan Hybrid Entity Designation

The Lockton, Inc. Welfare Benefit Plan (the "Covered Entity") is a single legal entity whose business activities include both functions subject to the provisions of the HIPAA privacy and security regulations found at 45 C.F.R. Parts 160 & 164 (the "Privacy and Security Regulations") and functions not subject to the Privacy and Security Regulations. Therefore, the Covered Entity is a "hybrid" covered entity for the purposes of the Privacy and Security Regulations. The covered functions of the Covered Entity include (i) the group medical program component, (ii) the PDP option and the PDP Co-Pay option of the group dental program component, (iii) the health care reimbursement portion of the flexible benefits program component, (iv) the group BTA medical program component, (v) the group vision program component, (vi) the group long-term care program component, (vii) the group critical illness program component, and (viii) the group wellness program component, and (ix) the group employee assistance program. All other functions of the Covered Entity are not covered functions under the Privacy and Security Regulations. As a "hybrid" covered entity, the Covered Entity will ensure that its covered health care components do not disclose Protected health Information ("PHI") to another non-covered component of the Lockton, Inc. Welfare Benefit Plan in violation of the Privacy and Security Regulations.

## The Use and Disclosure of Protected Health Information and Security of Electronic Protected Health Information

Under the federal privacy regulations enacted pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), your health plans are required to protect the confidentiality of your Protected Health Information. Protected Health Information (PHI) is individually identifiable health information related to your condition, services provided to you, or payments made for your care, which is created or received by a health plan, a health care clearinghouse, or a health care provider that electronically transmits such information. The Lockton, Inc. Welfare Benefit Plan and Lockton, Inc. will not use or disclose health information protected by HIPAA, except for treatment, payment, health plan operations (collectively known as "TPO"), as permitted or required by other state and federal law, or to business associates to help administer the Plan.

Further, Lockton, Inc. will take reasonable steps to ensure that any use or disclosure is the minimum necessary to accomplish the task.

In addition, under the federal security regulations enacted pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), your health plans are required to safeguard the confidentiality and ensure the integrity and availability of your Electronic Protected Health Information. Electronic Protected Health Information (ePHI) is PHI that is maintained or transmitted in electronic form. The Lockton, Inc. Welfare Benefit Plan and Lockton, Inc. will reasonably and appropriately safeguard ePHI created, received, maintained, or transmitted to or by Lockton, Inc. on behalf of the Plan.

The Lockton, Inc. Welfare Benefit Plan and Lockton, Inc. are separate and independent legal entities, which exchange information to coordinate your Plan coverage. In order to receive PHI from the Plan, Lockton, Inc. agrees to, and has certified to the Lockton, Inc. Welfare Benefit Plan, that it will:

- Not use or further disclose PHI other than as permitted or required by the Lockton, Inc. Welfare Benefit Plan or as required by law;
- Ensure that any agents, including subcontractors, to whom it provides PHI received from the Lockton, Inc. Welfare Benefit Plan agree to the same restrictions and conditions that apply to Lockton, Inc. with respect to such information;
- Not use or disclose PHI for employment-related actions and decisions;
- Not use or disclose PHI in connection with any other benefit or employee benefit plan of Lockton, Inc.;
- Notify the Lockton, Inc. Welfare Benefit Plan of any improper use or disclosure of PHI of which it becomes aware;
- Make PHI available to an individual based on HIPAA's access requirements;
- Make PHI available for amendment and incorporate any changes to PHI based on HIPAA's amendment requirements;
- Make available the information required to provide an accounting of disclosures of PHI;

- Make its internal practices, books and records relating to the use and disclosure of PHI received from the Lockton, Inc. Welfare Benefit Plan available to the Secretary of the U.S. Department of Health and Human Services to determine the Lockton, Inc. Welfare Benefit Plan's compliance with HIPAA;
- Ensure adequate separation between the Lockton, Inc. Welfare Benefit Plan and the Plan Sponsor as required by HIPAA; and
- If feasible, return or destroy all PHI received from the Lockton, Inc. Welfare Benefit Plan that Lockton, Inc. still maintains in any form and retain no copies of such PHI when no longer needed for the specified disclosure purpose. If return or destruction is not feasible, Lockton, Inc. will limit further uses and disclosures to those purposes that make the return or destruction infeasible.

In order to receive ePHI from the Plan, Lockton, Inc. agrees that it will:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that Lockton, Inc. creates, receives, maintains, or transmits on behalf of the Lockton, Inc. Welfare Benefit Plan;
- Ensure that access to, and use and disclosure of ePHI by the employees or classes of employees described in this Plan document is supported by reasonable and appropriate security measures;
- Ensure that any agent, including a subcontractor, to whom Lockton, Inc. provides this information agrees to implement reasonable and appropriate security measures to protect the information; and
- Report to the Plan any security incident of which Lockton, Inc. becomes aware.

Only the following employees under the control of Lockton, Inc. may have access to PHI or ePHI: Employees within Lockton, Inc.'s Associate Benefits Department. Such employees may only have access to, and use and disclose, PHI for purposes of the plan administrative functions described in this Plan document Lockton, Inc. performs for the group health plan. The Plan Sponsor has provided the following mechanism for resolving issues of noncompliance in the event one or more of the individuals listed above do not comply with the provisions outlined above, including disciplinary sanctions. In particular, if you believe your rights under HIPAA have been violated, you have the right to file a complaint with the Lockton, Inc. Welfare Benefit Plan or with the Secretary of the U.S. Department of Health and Human Services. Upon receipt of a complaint, the Lockton, Inc. Welfare Benefit Plan will investigate the complaint and reasonable steps will be taken to resolve the issue. Employees of the Plan Sponsor who do not comply with the provisions outlined above will be subject to disciplinary action, up to and including termination. If the Plan Sponsor fails to reasonably utilize this mechanism to resolve issues of noncompliance, the Lockton, Inc. Welfare Benefit Plan will not provide the Plan Sponsor with access to PHI or ePHI.

## SECTION 14 - GLOSSARY

**What this section includes:**
- Definitions of terms used throughout this SPD.

Many of the terms used throughout this SPD may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how Benefits are paid. This section defines terms used throughout this SPD, but it does not describe the Benefits provided by the Plan.

**Addendum** – any attached written description of additional or revised provisions to the Plan. The benefits and exclusions of this SPD and any amendments thereto shall apply to the Addendum except that in the case of any conflict between the Addendum and SPD and/or Amendments to the SPD, the Addendum shall be controlling.

**Alternate Facility** – a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- surgical services;
- Emergency Health Services; or
- rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health Services or Substance Use Disorder Services on an outpatient basis or inpatient basis (for example a Residential Treatment Facility).

**Amendment** – any attached written description of additional or alternative provisions to the Plan. Amendments are effective only when distributed by the Plan Sponsor or the Plan Administrator. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that the amendment is specifically changing.

**Annual Deductible (or Deductible)** – the amount you must pay for Covered Health Services in a calendar year before the Plan will begin paying Benefits in that calendar year. The Deductible is shown in the first table in Section 5, *Plan Highlights*. The Deductible applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 15, *Outpatient Prescription Drugs*.

**Benefits** – Plan payments for Covered Health Services, subject to the terms and conditions of the Plan and any Addendums and/or Amendments.

**Cancer Resource Services (CRS)** – a program administered by UnitedHealthcare or its affiliates made available to you by Lockton, Inc. The CRS program provides:

- specialized consulting services, on a limited basis, to Participants and enrolled Dependents with cancer;
- access to cancer centers with expertise in treating the most rare or complex cancers; and

- education to help patients understand their cancer and make informed decisions about their care and course of treatment.

**CHD** – see Congenital Heart Disease (CHD).

**Claims Administrator** – UnitedHealthcare (also known as UnitedHealthcare Services, Inc.) and its affiliates, who provide certain claim administration services for the Plan.

**Clinical Trial** – a scientific study designed to identify new health services that improve health outcomes. In a Clinical Trial, two or more treatments are compared to each other and the patient is not allowed to choose which treatment will be received.

**COBRA** – see Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

**Coinsurance** – the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works* and Section 15, *Outpatient Prescription Drugs*.

**Company** – Lockton, Inc.

**Congenital Anomaly** – a physical developmental defect that is present at birth and is identified within the first twelve months of birth.

**Congenital Heart Disease (CHD)** – any structural heart problem or abnormality that has been present since birth. Congenital heart defects may:

- be passed from a parent to a child (inherited);
- develop in the fetus of a woman who has an infection or is exposed to radiation or other toxic substances during her Pregnancy; or
- have no known cause.

**Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)** – a federal law that requires employers to offer continued health insurance coverage to certain employees and their dependents whose group health insurance has been terminated.

**Cosmetic Procedures** – procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator. Reshaping a nose with a prominent bump is a good example of a Cosmetic Procedure because appearance would be improved, but there would be no improvement in function like breathing.

**Cost-Effective** – the least expensive equipment that performs the necessary function. This term applies to Durable Medical Equipment and prosthetic devices.

**Covered Health Services** – those health services, including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be:

- provided for the purpose of preventing, diagnosing or treating Sickness, Injury, Mental Illness, substance-related and addictive disorders, or their symptoms;
- consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below;
- not provided for the convenience of the Covered Person, Physician, facility or any other person;
- included in Sections 5 and 6, Plan Highlights and Additional Coverage Details;
- provided to a Covered Person who meets the Plan's eligibility requirements, as described under *Eligibility* in Section 2, *Introduction*; and
- not identified in Section 8, *Exclusions*.

In applying the above definition, "scientific evidence" and "prevailing medical standards" have the following meanings:

- "scientific evidence" means the results of controlled Clinical Trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community; and
- "prevailing medical standards and clinical guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.

The Claims Administrator maintains clinical protocols that describe the scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. You can access these clinical protocols (as revised from time to time) on **www.myuhc.com** or by calling the number on the back of your ID card. This information is available to Physicians and other health care professionals on **www.UnitedHealthcareOnline.com**.

**Covered Person** – either the Participant or an enrolled Dependent, but this term applies only while the person is enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this SPD are references to a Covered Person.

**CRS** – see Cancer Resource Services (CRS).

**Custodial Care** – services that are any of the following:

- non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, , transferring and ambulating);
- health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence; or

- services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

**Deductible** – see Annual Deductible.

**Dependent** – an individual who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. A Dependent does not include anyone who is also enrolled as a Participant. No one can be a Dependent of more than one Participant.

**Designated Facility** – a facility that has entered into an agreement with the Claims Administrator or with an organization contracting on behalf of the Plan, to render Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within your geographic area. The fact that a Hospital is a Network Hospital does not mean that it is a Designated Facility.

**Designated Physician** - a Physician that the Claims Administrator identified through its designation programs as a Designated provider. A Designated Physician may or may not be located within your geographic area. The fact that a Physician is a Network Physician does not mean that he or she is a Designated Physician.

**DME** – see Durable Medical Equipment (DME).

**Domestic Partner** – an adult who is:

- age 18 or over;
- not related to you;
- living with you and has shared a common household for at least 6 continuous months;
- not currently in a marriage, domestic partnership, or civil union with a different person; and
- in a committed, exclusive relationship of mutual caring and support with you, and you are mutually responsible (legally and financially) for each other (or the domestic partner is chiefly dependent on you for care and assistance).

You must complete the required verification of domestic partner status and/or provide any necessary documentation required by the Plan Administrator or Lockton, Inc., in order to establish the status of a Domestic Partner.

**Domiciliary Care** – living arrangements designed to meet the needs of people who cannot live independently but do not require Skilled Nursing Facility services.

**Durable Medical Equipment (DME)** – medical equipment that is all of the following:

- is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms;
- is not disposable;

- is generally not useful to a person in the absence of a Sickness, Injury or their symptoms;
- can withstand repeated use;
- is not implantable within the body; and
- is appropriate for use, and is primarily used, within the home.

**Eligible Expenses** - –for Covered Health Services incurred while the Plan is in effect, Eligible Expenses are determined by UnitedHealthcare as stated below and as detailed in Section 3, *How the Plan Works*.

Eligible Expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines. UnitedHealthcare develops the reimbursement policy guidelines, in UnitedHealthcare's discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that UnitedHealthcare accept.

**Emergency** – a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness, or Substance Use Disorders which:

- arises suddenly; and
- in the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

Notwithstanding the above, the term Emergency shall also include a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of an individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

**Emergency Health Services** – health care services and supplies necessary for the treatment of an Emergency. Notwithstanding the above, the term Emergency Health Services shall, with respect to an Emergency, also include (a) a medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency, and (b) such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under Section 1867 of the Social Security Act to stabilize the patient.

**Employee Retirement Income Security Act of 1974 (ERISA)** – the federal legislation that regulates retirement and employee welfare benefit programs maintained by employers and unions.

**Employer** – Lockton, Inc.

**EOB** – see Explanation of Benefits (EOB).

**ERISA** – see Employee Retirement Income Security Act of 1974 (ERISA).

**Experimental or Investigational Services** – medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time the Claims Administrator and Lockton, Inc. make a determination regarding coverage in a particular case, are determined to be any of the following:

- not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use;
- subject to review and approval by any institutional review board for the proposed use (Devices which are FDA approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational); or
- the subject of an ongoing Clinical Trial that meets the definition of a Phase I, II or III Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exceptions:

- Clinical Trials for which Benefits are available as described under Clinical Trials in Section 6, *Additional Coverage Details*; and
- If you are not a participant in a qualifying Clinical Trial as described under Section 6, *Additional Coverage Details*, and have a Sickness or condition that is likely to cause death within one year of the request for treatment, the Claims Administrator and Lockton, Inc. may, at their discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, the Claims Administrator and Lockton, Inc. must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

**Explanation of Benefits (EOB)** – a statement provided by UnitedHealthcare to you, your Physician, or another health care professional that explains:

- the Benefits provided (if any);
- the allowable reimbursement amounts;
- Deductibles;

- Coinsurance;
- any other reductions taken;
- the net amount paid by the Plan; and
- the reason(s) why the service or supply was not covered by the Plan.

**Health Statement(s)** – a single, integrated statement that summarizes EOB information by providing detailed content on account balances and claim activity.

**Home Health Agency** – a program or organization authorized by law to provide health care services in the home.

**Hospital** – an institution, operated as required by law, which is:

- primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of sick or injured individuals. Care is provided through medical, mental health, substance-related and addictive disorders, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians; and
- has 24 hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a Skilled Nursing Facility, convalescent home or similar institution.

**Injury** – bodily damage other than Sickness, including all related conditions and recurrent symptoms.

**Inpatient Rehabilitation Facility** – a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

**Inpatient Stay** – an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

**Intensive Outpatient Treatment** – a structured outpatient mental health or substance-related and addictive disorders treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

**Intermittent Care** – skilled nursing care that is provided or needed either:

- fewer than seven days each week; or
- fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in special circumstances when the need for additional care is finite and predictable.

**Manipulative Treatment** – the therapeutic application of chiropractic and/or manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

**Medicaid** – a federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

**Medicare** – Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

**Mental Health Services** – Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

**Mental Health/Substance Use Disorder (MH/SUD) Administrator** – the organization or individual designated by Lockton, Inc. who provides or arranges Mental Health and Substance Use Disorder Services under the Plan.

**Mental Illness** – mental health or psychiatric diagnostic categories listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless they are listed in Section 8, *Exclusions*.

**Network** – when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with its affiliate to participate in the Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services by way of their participation in the Shared Savings Program. The Claims Administrator's affiliates are those entities affiliated with the Claims Administrator through common ownership or control with the Claims Administrator or with the Claims Administrator's ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

**Network Benefits** - This is the description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to Section 3, *How the Plan Works*, for details about how Network Benefits apply.

**Non-Network Benefits** - This is the description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to Section 3, *How the Plan Works*, for details about how Non-Network Benefits apply.

**Open Enrollment** – the period of time, determined by Lockton, Inc., during which eligible Participants may enroll themselves and their Dependents under the Plan. Lockton, Inc. determines the period of time that is the Open Enrollment period.

**Out-of-Pocket Maximum** – the maximum amount you pay every calendar year. Refer to Section 5, *Plan Highlights* for the Out-of-Pocket Maximum amount. See Section 3, *How the Plan Works* for a description of how the Out-of-Pocket Maximum works.

**Partial Hospitalization/Day Treatment** – a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

**Participant** – a full-time or part-time employee of the Employer who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*, and Addendum B, *Additional Eligibility Provision*. A Participant must live and/or work in the United States. For purposes of this definition of Participant and for purposes of the eligibility provisions of the Plan, the following rules shall apply: (i) the term "Employer" means the Plan Sponsor and any other entity within the Plan Sponsor's controlled group under Sections 414(b), (c) and (m) of the Tax Code (as such sections may be amended from time to time); and (ii) the term "employee" shall include both employees and self-employed individuals.

**Personal Health Support** – programs provided by the Claims Administrator that focus on prevention, education, and closing the gaps in care designed to encourage an efficient system of care for you and your covered Dependents.

**Personal Health Support Nurse** – the primary nurse that UnitedHealthcare may assign to you if you have a chronic or complex health condition. If a Personal Health Support Nurse is assigned to you, this nurse will call you to assess your progress and provide you with information and education.

**Pharmaceutical Product(s)** – *U.S. Food and Drug Administration (*FDA)-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under the Plan.

**Physician** – any Doctor of Medicine or Doctor of Osteopathy who is properly licensed and qualified by law.

Please note: Any podiatrist, dentist, psychologist, chiropractor, optometrist or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that a provider is described as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

**Plan** – the group medical program component of the Lockton, Inc. Welfare Benefit Plan.

**Plan Administrator** – the Benefits Administration Committee of Lockton, Inc.

**Plan Sponsor** – Lockton, Inc.

**Pregnancy** – includes prenatal care, postnatal care, childbirth, and any complications associated with Pregnancy.

**Private Duty Nursing** – nursing care that is provided to a patient on a one-to-one basis by licensed nurses in a home setting when any of the following are true:

- no skilled services are identified;
- skilled nursing resources are available in the facility;
- the skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose; or
- the service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on a home-care basis, whether the service is skilled or non-skilled independent nursing.

**Reconstructive Procedure** – a procedure performed to address a physical impairment where the expected outcome is restored or improved function. The primary purpose of a Reconstructive Procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not changed or improved physical appearance. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure.

**Residential Treatment Facility** – a facility which provides a program of effective Mental Health Services or Substance Use Disorder Services treatment and which meets all of the following requirements:

- it is established and operated in accordance with applicable state law for residential treatment programs;
- it provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance Use Disorder Administrator;
- it has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient; and
- it provides at least the following basic services in a 24-hour per day, structured milieu:
  - room and board;
  - evaluation and diagnosis;
  - counseling; and
  - referral and orientation to specialized community resources.

A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital.

**Semi-private Room** - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

**Shared Savings Program** - the Shared Savings Program provides access to discounts from non-Network Physicians who participate in that program. UnitedHealthcare will use the Shared Savings Program to pay claims when doing so will lower Eligible Expenses. While UnitedHealthcare might negotiate lower Eligible Expenses for Non-Network Benefits, the Coinsurance will stay the same as described in Section 5, *Plan Highlights*.

UnitedHealthcare does not credential the Shared Savings Program providers and the Shared Savings Program providers are not Network providers. Accordingly, in benefit plans that have both Network and non-Network levels of Benefits, Benefits for Covered Health Services provided by Shared Savings Program providers will be paid at the non-Network Benefit level (except in situations when Benefits for Covered Health Services provided by non-Network providers are payable at Network Benefit levels, as in the case of Emergency Health Services). When UnitedHealthcare uses the Shared Savings Program to pay a claim, the patient responsibility is limited to Coinsurance calculated on the contracted rate paid to the provider, in addition to any required Annual Deductible.

**Sickness** – physical illness, disease or Pregnancy. The term Sickness as used in this SPD includes Mental Illness or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorders.

**Skilled Care** – skilled nursing, teaching, and rehabilitation services when:

- they are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient;
- a Physician orders them;
- they are not delivered for the purpose of assisting with activities of daily living, including, but not limited to, dressing, feeding, bathing or transferring from a bed to a chair;
- they require clinical training in order to be delivered safely and effectively; and
- they are not Custodial Care, as defined in this section.

**Skilled Nursing Facility** – a nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility that is part of a Hospital is considered a Skilled Nursing Facility for purposes of the Plan.

**Spouse** – an individual who is either an opposite sex spouse or a same-sex spouse to whom an eligible Participant is married.

**Substance Use Disorder Services** - Covered Health Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

**Total Disability** – a Participant's inability to perform all substantial job duties because of physical or mental impairment, or a Dependent's inability to perform the normal activities of a person of like age and gender.

**Transitional Care** – Mental Health Services/Substance Use Disorder Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- sober living arrangements such as drug-free housing, alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery; or
- supervised living arrangement which are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

**Unproven Services** – health services, including medications that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature:

- Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received.
- Well-conducted cohort studies from more than one institution are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

UnitedHealthcare has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, UnitedHealthcare issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at **www.myuhc.com**.

**Please note:** If you have a life threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), UnitedHealthcare and Lockton, Inc. may, at their discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, UnitedHealthcare and Lockton, Inc. must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

The decision about whether such a service can be deemed a Covered Health Service is solely at UnitedHealthcare's and Lockton, Inc.'s discretion. Other apparently similar promising but unproven services may not qualify.

**Urgent Care** – treatment of an unexpected Sickness or Injury that is not life-threatening but requires outpatient medical care that cannot be postponed. An urgent situation requires prompt medical attention to avoid complications and unnecessary suffering, such as high fever, a skin rash, or an ear infection.

**Urgent Care Center** – a facility that provides Urgent Care services, as previously defined in this section. In general, Urgent Care Centers:

- do not require an appointment;
- are open outside of normal business hours, so you can get medical attention for minor illnesses that occur at night or on weekends; and
- provide an alternative if you need immediate medical attention, but your Physician cannot see you right away.

# SECTION 15 - OUTPATIENT PRESCRIPTION DRUGS

**What this section includes:**

- Benefits available for Prescription Drug Products;
- How to utilize the retail and mail order service for obtaining Prescription Drug Products;
- Any Benefit limitations and exclusions that exist for Prescription Drug Products; and
- Definitions of terms used throughout this section related to the Prescription Drug Product Plan.

## Prescription Drug Product Coverage Highlights

The table below provides an overview of the Plan's Prescription Drug coverage. It includes Coinsurance amounts that apply when you have a prescription filled at a Network Pharmacy after you meet the Annual Deductible stated in Section 5, *Plan Highlights*. For detailed descriptions of your Benefits, refer to *Retail* and *Mail Order* in this section.

The Out-of-Pocket Maximum applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 6, *Additional Coverage Details*.

You are responsible for paying any amounts due to the pharmacy at the time you receive your prescription drugs and you have not met your Deductible. You are not responsible for paying a Coinsurance for Preventive Care Medications. Benefits for Preventive Care Medications are not subject to payment of the Annual Deductible.

| Covered Health Services[1] | Percentage of Prescription Drug Cost Payable by the Plan: | Percentage of Predominant Reimbursement Rate Payable by the Plan: |
|---|---|---|
| | Network | Non-Network |
| **Retail** - up to a 90-day supply | | |
| ■ tier-1 | 80% after you meet the Annual Deductible. | Not Covered |
| ■ tier-2 | 80% after you meet the Annual Deductible. | Not Covered |
| ■ tier-3 | 80% after you meet the Annual Deductible. | Not Covered |

| Covered Health Services[1] | Percentage of Prescription Drug Cost Payable by the Plan: | Percentage of Predominant Reimbursement Rate Payable by the Plan: |
|---|---|---|
| | Network | Non-Network |
| **Prescription Drugs on the Expanded List of Preventive Medications** | | |
| ■ tier-1 | 100% | Not Covered |
| ■ tier-2 | 100% | Not Covered |
| ■ tier-3 | 100% | Not Covered |
| **Mail order** - up to a 90-day supply | | |
| ■ tier-1 | 80% after you meet the Annual Deductible. | Not Covered |
| ■ tier-2 | 80% after you meet the Annual Deductible. | Not Covered |
| ■ tier-3 | 80% after you meet the Annual Deductible. | Not Covered |

[1]You, your Physician or your pharmacist must notify UnitedHealthcare to receive full Benefits for certain Prescription Drugs. Otherwise, you may pay more out-of-pocket. See *Notification Requirements* in this section for details.

***Note***: The Coordination of Benefits provision described in Section 10, *Coordination of Benefits (COB)* applies to covered Prescription Drugs as described in this section. Benefits for Prescription Drugs will be coordinated with those of any other health plan in the same manner as Benefits for Covered Health Services described in this SPD.

## Identification Card (ID Card) – Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by the UnitedHealthcare during regular business hours.

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug at the pharmacy.

You may seek reimbursement from the Plan as described in Section 9, *Claims Procedures*, under the heading, *How to File a Claim*. When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was

dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Coinsurance, and any deductible that applies.

## Benefit Levels

Benefits are available for outpatient Prescription Drug Products that are considered Covered Health Services.

The Plan pays Benefits at the same level for tier-1, tier-2 and tier-3 Prescription Drug Products. All Prescription Drug Products covered by the Plan are categorized into these three tiers on the Prescription Drug List (PDL). The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug, depending on its tier assignment. Since the PDL may change periodically, you can visit **www.myuhc.com** or call UnitedHealthcare at the toll-free number on your ID card for the most current information.

The Coinsurance is the amount you pay after you have met the Annual Deductible when you visit the pharmacy or order your medications through mail order. Your Coinsurance will also depend on whether or not you visit the pharmacy or use the mail order service - see the table shown at the beginning of this section for further details.

Coinsurance for a Prescription Drug at a Network Pharmacy is a percentage of the Prescription Drug Charge.

For Prescription Drugs at a retail Network Pharmacy, you are responsible for paying the lower of:

- the Coinsurance;
- the Network Pharmacy's Usual and Customary Charge for the Prescription Drug; or
- the Prescription Drug Charge that UnitedHealthcare agreed to pay the Network Pharmacy.

For Prescription Drugs from a mail order Network Pharmacy, you are responsible for paying the lower of:

- the Coinsurance; or
- the Prescription Drug Charge for that particular Prescription Drug.

## Retail

The Plan has a Network of participating retail pharmacies, which includes many large drug store chains. You can obtain information about Network Pharmacies by contacting UnitedHealthcare at the toll-free number on your ID card or by logging onto **www.myuhc.com**.

To obtain your prescription from a Network Pharmacy, simply present your ID card and pay the Coinsurance after meeting the Annual Deductible. The Plan pays Benefits for certain covered Prescription Drugs:

- as written by a Physician;
- up to a consecutive 90-day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits;
- when a Prescription Drug is packaged or designed to deliver in a manner that provides more than a consecutive 90-day supply, the Coinsurance that applies will reflect the number of days dispensed; and
- a one-cycle supply of an oral contraceptive. You may obtain up to three cycles at one time if you pay the Coinsurance for each cycle supplied (Coinsurance will not apply to the extent oral contraceptives are covered as Preventive Care Medications).

If you purchase a Prescription Drug from a non-Network Pharmacy, you will be required to pay full price and will not receive reimbursement under the Plan.

***Note:*** Network Pharmacy Benefits apply only if your prescription is for a Covered Health Service, and not for Experimental or Investigational, or Unproven Services. Otherwise, you are responsible for paying 100% of the cost.

### Mail Order

The mail order service may allow you to purchase up to a 90-day supply of a covered maintenance drug through the mail from a Network Pharmacy. Maintenance drugs help in the treatment of chronic illnesses, such as heart conditions, allergies, high blood pressure, and arthritis.

To use the mail order service, all you need to do is complete a patient profile and enclose your Prescription Order or Refill. Your medication, plus instructions for obtaining refills, will arrive by mail about 14 days after your order is received. If you need a patient profile form, or if you have any questions, you can reach UnitedHealthcare at the toll-free number on your ID card.

The Plan pays mail order Benefits for certain covered Prescription Drugs:

- as written by a Physician; and
- up to a consecutive 90-day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits.

***Note:*** To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged the mail order Coinsurance for any Prescription Order or Refill if you use the mail order service, regardless of the number of days' supply that is written on the order or refill. Be sure your Physician writes your mail order or refill for a 90-day supply, not a 30-day supply with three refills.

## Benefits for Preventive Care Medications

Benefits under the Prescription Drug Plan include those for Preventive Care Medications as defined under Glossary – Prescription Drugs. You may determine whether a drug is a Preventive Care Medication through the internet at www.myuhc.com or by calling UnitedHealthcare at the toll-free telephone number on your ID card.

## Designated Pharmacy

If you require certain Prescription Drug Products, UnitedHealthcare may direct you to a Designated Pharmacy with whom it has an arrangement to provide those Prescription Drug Products.

Please see the Prescription Drug Glossary in this section for definition of Designated Pharmacy.

**Want to lower your out-of-pocket Prescription Drug costs?**
Consider tier-1 Prescription Drug Products, if you and your Physician decide they are appropriate.

## Assigning Prescription Drugs to the PDL

UnitedHealthcare's Prescription Drug List (PDL) Management Committee is authorized to make tier placement changes on UnitedHealthcare's behalf. The PDL Management Committee makes the final classification of an FD-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or notification requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, available rebates and assessments on the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are most cost effective for specific indications as compared to others, therefore, a Prescription Drug Product may be listed on multiple tiers according to the indication for which the Prescription Drug was prescribed.

The PDL Management Committee may periodically change the placement of a Prescription Drug Product among the tiers. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to you.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

***Note***: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, you may be required to pay more or

less for that Prescription Drug Product. Please access **www.myuhc.com** through the Internet or call the number on your ID card for the most up-to-date tier status.

Prescription Drug, Prescription Drug List (PDL), and Prescription Drug List (PDL) Management Committee are defined at the end of this section.

**Prescription Drug List (PDL)**
The Prescription Drug List (PDL) is a tool that helps guide you and your Physician in choosing the medications that allow the most effective and affordable use of your Prescription Drug Benefit.

## Notification Requirements

Before certain Prescription Drug Products are dispensed to you, it is the responsibility of your Physician, your pharmacist or you to notify UnitedHealthcare or its designee. UnitedHealthcare or its designee is to determine if the Prescription Drug Product, in accordance with UnitedHealthcare's approved guidelines, is each of the following:

- it meets the definition of a Covered Health Service as defined by the Plan; and
- it is not an Experimental or Investigational or Unproven Service, as defined in Section 14, *Glossary*.

### *Network Pharmacy Notification*

When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for notifying UnitedHealthcare.

If UnitedHealthcare is not notified before the Prescription Drug Product is dispensed, you can ask UnitedHealthcare to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from the Plan as described in Section 9, *Claims Procedures*.

When you submit a claim on this basis, you may pay more because you did not notify UnitedHealthcare before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Coinsurance and any Deductible that applies.

To determine if a Prescription Drug Product requires notification, either visit **www.myuhc.com** or call the toll-free number on your ID card. The Prescription Drug Products requiring notification are subject to UnitedHealthcare's periodic review and modification.

Benefits may not be available for the Prescription Drug Product after the UnitedHealthcare reviews the documentation provided and determines that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

UnitedHealthcare may also require notification for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable notification, participation or activation requirements associated with such programs through the Internet at **www.myuhc.com** or by calling the number on your ID card.

### Prescription Drug Benefit Claims

For Prescription Drug Product claims procedures, please refer to Section 9, *Claims Procedures*.

### Limitation on Selection of Pharmacies

If UnitedHealthcare determines that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, UnitedHealthcare may require you to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within 31 days of the date the Plan Administrator notifies you, UnitedHealthcare will select a single Network Pharmacy for you.

### Supply Limits

Some Prescription Drug Products are subject to supply limits that may restrict the amount dispensed per Prescription Order or Refill, you may receive a Prescription Drug Product up to the stated supply limit. To determine if a Prescription Drug Product has been assigned a maximum quantity level for dispensing, either visit **www.myuhc.com** or call the toll-free number on your ID card. Whether or not a Prescription Drug Product has a supply limit is subject to UnitedHealthcare's periodic review and modification.

***Note:*** Some products are subject to additional supply limits based on criteria that the Plan Administrator and UnitedHealthcare have developed, subject to periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply.

### If a Brand-name Drug Becomes Available as a Generic

If a Brand-name Prescription Drug Product becomes available as a Generic drug, the tier placement of the Brand-name Prescription Drug Product may change.

### Special Programs

Lockton, Inc. and UnitedHealthcare may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at **www.myuhc.com** or by calling the number on the back of your ID card.

### Maintenance Medication Program

If you require certain Maintenance Medications, UnitedHealthcare may direct you to the Mail Order Network Pharmacy to obtain those Maintenance Medications.

## Rebates and Other Discounts

UnitedHealthcare and Lockton, Inc. may, at times, receive rebates for certain drugs on the PDL, including those drugs that you purchase prior to meeting your Annual Deductible. UnitedHealthcare does not pass these rebates on to you, nor are they combined medical and pharmacy Annual Deductible or taken into account in determining your Coinsurance.

UnitedHealthcare and a number of its affiliated entities, conduct business with various pharmaceutical manufacturers separate and apart from this Outpatient Prescription Drug section. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this Outpatient Prescription Drug section. UnitedHealthcare is not required to pass on to you, and does not pass on to you, such amounts.

## Coupons, Incentives and Other Communications

UnitedHealthcare may send mailings to you or your Physician that communicate a variety of messages, including information about Prescription Drugs. These mailings may contain coupons or offers from pharmaceutical manufacturers that allow you to purchase the described Prescription Drug at a discount or to obtain it at no charge. Pharmaceutical manufacturers may pay for and/or provide the content for these mailings. Only your Physician can determine whether a change in your Prescription order or refill is appropriate for your medical condition.

UnitedHealthcare may not permit certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at **www.myuhc.com** or by calling the number on your ID card.

## Exclusions - What the Prescription Drug Plan Will Not Cover

Exclusions from coverage listed in Section 8, *Exclusions* also apply to this section. In addition, the exclusions listed below apply.

When an exclusion applies to only certain Prescription Drug Products, you can access **www.myuhc.com** through the Internet or by calling the number on your ID card for information on which Prescription Drug Products are excluded.

Medications that are:

1. dispensed by a non-Network Pharmacy;

2. for any condition, Injury, Sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received;

3. any Prescription Drug Product for which payment or benefits are provided or available from the local, state or federal government (for example Medicare) whether or not payment or benefits are received, except as otherwise provided by law;

4. Pharmaceutical Products for which Benefits are provided in the medical (not in Section 15, *Outpatient Prescription Drugs*) portion of the Plan;

5. available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Plan Administrator has designated over-the-counter medication as eligible for coverage as if it were a Prescription Drug Order and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that the Plan Administrator has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and the Plan Administrator may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision;

6. Compounded drugs that do not contain at least one ingredient that has been approved by the *U.S. Food and Drug Administration (FDA)* and requires a Prescription Order or Refill. Compounded drugs that contain a non-*FDA* approved bulk chemical. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier-3);

7. dispensed outside of the United States, except in an Emergency;

8. Durable Medical Equipment (prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered);

9. growth hormone for children with familial short stature based on heredity and not caused by a diagnosed medical condition);

10. the amount dispensed (days' supply or quantity limit) which exceeds the supply limit;

11. The amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit;

12. new drugs and/or new dosages, until they are reviewed and assigned to a tier by the PDL Management Committee;

13. prescribed, dispensed or intended for use during an Inpatient Stay;

14. prescribed for appetite suppression, and other weight loss products;

15. prescribed to treat infertility;

16. Prescription Drug Products, including new Prescription Drug Products or new dosage forms, that UnitedHealthcare and Lockton, Inc. determines do not meet the definition of a Covered Health Service;

17. Prescription Drug Products that contain (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product;

18. Prescription Drugs that contain (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product;

19. typically administered by a qualified provider or licensed health professional in an outpatient setting. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception;

20. unit dose packaging of Prescription Drug Products;

21. used for conditions and/or at dosages determined to be Experimental or Investigational, or Unproven, unless UnitedHealthcare and Lockton, Inc. have agreed to cover an Experimental or Investigational or Unproven treatment, as defined in Section 14, *Glossary*;

22. Prescription Drug Product as a replacement for a previously dispensed Prescription Drug that was lost, stolen, broken or destroyed;

23. used for cosmetic purposes; and

24. vitamins, except for the following which require a prescription:

    - prenatal vitamins;
    - vitamins with fluoride; and
    - single entity vitamins.

## Glossary - Prescription Drugs

**Brand-name** - a Prescription Drug Product that is either:

- manufactured and marketed under a trademark or name by a specific drug manufacturer; or
- identified by UnitedHealthcare as a Brand-name product based on available data resources including, but not limited to, Medi-Span, that classify drugs as either brand or generic based on a number of factors.

You should know that all products identified as "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by UnitedHealthcare.

**Chemically Equivalent** - when Prescription Drug Products contain the same active ingredient.

**Designated Pharmacy** - a pharmacy that has entered into an agreement with UnitedHealthcare or with an organization contracting on its behalf, to provide specific Prescription Drug Products. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

**Generic** - a Prescription Drug that is either:

- Chemically Equivalent to a Brand-name drug; or
- identified by UnitedHealthcare as a Generic Drug based on available data resources, including, but not limited to, Medi-Span, that classify drugs as either brand or generic based on a number of factors.

You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by the Claims Administrator.

**List of Preventive Medications** – a list that identifies certain Prescription Drug Products on the Prescription Drug List that are intended to reduce the likelihood of Sickness. You may obtain the List of Preventive Medications through the Internet at **www.myuhc.com** or by calling the number on the back of your ID card.

**Maintenance Medication –** a Prescription Drug Product anticipated to be used for six months or more to treat or prevent a chronic condition. You may determine whether a Prescription Drug Product is a Maintenance Medication through the Internet at **www.myuhc.com** or by calling the telephone number on your ID card.

**Network Pharmacy** - a pharmacy that has:

- entered into an agreement with UnitedHealthcare or an organization contracting on its behalf to provide Prescription Drug Products to Covered Persons;
- agreed to accept specified reimbursement rates for dispensing Prescription Drug Products; and
- been designated by UnitedHealthcare as a Network Pharmacy.

**New Prescription Drug Product** - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

- the date it is assigned to a tier by UnitedHealthcare's PDL Management Committee;
- December 31st of the following calendar year.

**PDL** - see Prescription Drug List (PDL).

**PDL Management Committee** - see Prescription Drug List (PDL) Management Committee.

**Prescription Drug Charge** – the rate UnitedHealthcare has agreed to pay its Network Pharmacies, including the applicable dispensing fee and any applicable sales tax, for a Prescription Drug dispensed at a Network Pharmacy.

**Prescription Drug List (PDL)** - a list that categorizes into tiers medications, products or devices that have been approved by the *U.S. Food and Drug Administration*. This list is subject to UnitedHealthcare's periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Prescription Drug Product has been assigned by contacting UnitedHealthcare at the toll-free number on your ID card or by logging onto **www.myuhc.com**.

**Prescription Drug List (PDL) Management Committee** - the committee that UnitedHealthcare designates for, among other responsibilities, classifying Prescription Drug Products into specific tiers.

**Prescription Drug Product** - a medication, product or device that has been approved by the *U.S. Food and Drug Administration (FDA)* and that can, under federal or state law, only be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For purposes of Benefits under this Plan, this definition includes:

- inhalers (with spacers);
- insulin;
- the following diabetic supplies:
  - insulin syringes with needles;
  - blood-testing strips – glucose;
  - urine-testing strips – glucose;
  - ketone-testing strips and tablets;
  - lancets and lancet devices;
  - insulin pump supplies, including infusion sets, reservoirs, glass cartridges, and insertion sets; and
  - glucose monitors.

**Prescription Order or Refill** - the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

**Preventive Care Medications –** the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Copayment, Coinsurance, Annual Deductible, Annual Prescription Drug Deductible or Specialty Prescription Drug Product Annual Deductible, if any) as required by applicable law under any of the following:

- evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;

- with respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; or
- with respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

You may determine whether a drug is a Preventive Care Medication through the internet at www.myuhc.com or by calling UnitedHealthcare at the toll-free telephone number on your ID card.

**Therapeutically Equivalent** – when Prescription Drug Products have essentially the same efficacy and adverse effect profile.

**Usual and Customary Charge** – the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax.

# SECTION 16 - IMPORTANT ADMINISTRATIVE INFORMATION: ERISA

**What this section includes:**
- Plan administrative information, including your rights under ERISA.

This section includes information on the administration of the Plan, as well as information required of all Summary Plan Descriptions by ERISA as defined in Section 14, *Glossary*. While you may not need this information for your day-to-day participation, it is information you may find important.

### *Plan Sponsor and Administrator*

Lockton, Inc. is the Plan Sponsor of, and Lockton, Inc.'s Benefits Administration Committee is the Plan Administrator of, the Lockton, Inc. Welfare Benefit Plan. The Plan Administrator has the discretionary authority to interpret the Plan. You may contact the Plan Sponsor and the Plan Administrator at:

**Plan Sponsor**
Lockton, Inc.
444 West 47th Street, Suite 900
Kansas City, MO 64112-1906
(816) 960-9000

**Plan Administrator**
Benefits Administration Committee
c/o Lockton, Inc.
444 West 47th Street, Suite 900
Kansas City, MO 64112-1906
(816) 960-9000

A complete list of the Lockton entities sponsoring the Lockton, Inc. Welfare Benefit Plan may be obtained by participants and beneficiaries upon written request to the Plan Administrator, and is available for examination by participants and beneficiaries.

### *Claims Administrator*

UnitedHealthcare is the Plan's Claims Administrator. The role of the Claims Administrator is to handle the day-to-day administration of the Plan's coverage as directed by the Plan Administrator, through an administrative agreement with the Company. The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of Benefits under the Plan Sponsor's Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

You may contact the Claims Administrator by phone at the number on your ID card or in writing at:

UnitedHealthcare Services, Inc.
9900 Bren Road East
Minnetonka, MN 55343

### *Agent for Service of Legal Process*

Should it ever be necessary, you or your personal representative may serve legal process on the agent of service for legal process for the Plan. The Plan's Agent of Service is:

Lockton, Inc.
444 West 47th Street, Suite 900
Kansas City, MO 64112-1906
(816) 960-9000

Legal process may also be served on the Plan Administrator.

### *Other Administrative Information*

This section of your SPD contains information about how the Plan is administered as required by ERISA.

### *Type of Administration*

The Plan is a self-funded welfare Plan and the administration is provided through one or more third party administrators.

| | |
|---|---|
| **Plan Name:** | Lockton, Inc. Welfare Benefit Plan |
| **Plan Number:** | 501 |
| **Employer ID:** | 90-0007886 |
| **Plan Type:** | Welfare benefits plan (and, specifically, the Plan provides group health benefits) |
| **Plan Year:** | January 1 through December 31 |
| **Plan Administration:** | Self-Insured |
| **Source of Plan Contributions:** | Participant and Company (Participant contributions will be determined and communicated to you by Lockton, Inc. from time to time) |
| **Source of Benefits:** | Assets of the Company |

### *Your ERISA Rights*

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be permitted to:

- receive information about Plan Benefits;
- examine, without charge, at the Plan Administrator's office and at other specified worksites, all plan documents – including pertinent insurance contracts, collective bargaining agreements (if applicable), and other documents (such as the latest Form 5500 series annual report) available at the Public Disclosure Room of the Employee Benefits Security Administration; and

- obtain copies of all Plan documents and other Plan information, including insurance contracts and collective bargaining agreements (if applicable), and the latest Form 5500 annual report and updated Summary Plan Description, by writing to the Plan Administrator. The Plan Administrator may make a reasonable charge for copies.
- receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of the summary annual report.

You can continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the Plan documents to understand the rules governing your COBRA continuation coverage rights. In addition to creating rights for Plan participants, ERISA imposes duties on the people who are responsible for the operation of the Plan. The people who operate your Plan, who are called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan Benefit or exercising your rights under ERISA.

If your claim for a Plan Benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. See Section 9, *Claims Procedures*, for details.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the plan document from the Plan, and do not receive it within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent for reasons beyond the control of the Plan Administrator.

If you have a claim for Benefits, which is denied or ignored, in whole or in part, and you have exhausted the administrative remedies available under the Plan, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in federal court. If it should happen that the Plan's fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or write to the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200

Constitution Avenue N.W. Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at (866) 444-3272.

The Plan's Benefits are administered by Lockton, Inc., the Plan Administrator. UnitedHealthcare is the Claims Administrator and processes claims for the Plan and provides appeal services; however, UnitedHealthcare and Lockton, Inc. are not responsible for any decision you or your Dependents make to receive treatment, services or supplies, whether provided by a Network or non-Network provider. UnitedHealthcare and Lockton, Inc. are neither liable nor responsible for the treatment, services or supplies provided by Network or non-Network providers.

# ATTACHMENT I - HEALTH CARE REFORM NOTICES

## Patient Protection and Affordable Care Act ("PPACA")

### *Patient Protection Notices*

The Claims Administrator generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Claims Administrator's network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator at the number on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Claims Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Claims Administrator at the number on the back of your ID card.

# ATTACHMENT II - LEGAL NOTICES

## Women's Health and Cancer Rights Act of 1998

As required by the Women's Health and Cancer Rights Act of 1998, Lockton, Inc. provides Benefits under the Plan for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

## Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health Plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your issuer.

# ATTACHMENT III - HEALTH SAVINGS ACCOUNT

**What this attachment includes:**

- About Health Savings Accounts;
- Who is eligible and how to enroll;
- Contributions;
- Additional medical expense coverage available with your Health Savings Account;
- Using the HSA for Non-Qualified Expenses; and
- Rolling over funds in your HSA.

## Introduction

This attachment to the Summary Plan Description (SPD) describes some key features of the Health Savings Account (HSA) that you could establish to complement the group medical program component of the Lockton, Inc. Welfare Benefit Plan, which is a high deductible medical plan. In particular, and except as otherwise indicated, this attachment will address the Health Savings Account, and not the high deductible health plan that is associated with the "HSA".

Lockton, Inc. has entered into an agreement with United HealthCare Services, Inc., Hartford, CT, ("UnitedHealthcare") under which UnitedHealthcare will provide certain administrative services to the Plan.

UnitedHealthcare does not insure the benefits described in this attachment. Further, note that it is our intention to comply with Department of Labor guidance set forth in Field Assistance Bulletin No. 2004-1, which specifies that an HSA is not an ERISA plan if certain requirements are satisfied.

The HSA described in this section is not an arrangement that is established and maintained by Lockton, Inc. rather; the HSA is established and maintained by the HSA trustee. However, for administrative convenience, a description of the HSA is provided in this section.

## About Health Savings Accounts

You gain choice and control over your health care decisions and expenditures when you establish your HSA to complement the high deductible medical plan described in the SPD.

An HSA is an account funded by you, your employer, or any other person on your behalf. The HSA can help you to cover, on a tax free basis, medical plan expenses that require you to pay out-of-pocket, such as Deductibles or Coinsurance. It may even be used to pay for, among other things, certain medical expenses not covered under the medical plan design. Amounts may be distributed from the HSA to pay non-medical expenses, however, these amounts are subject to income tax and may be subject to 20% penalty.

You have three tools you can use to meet your health care needs:

- The group medical program component of the Lockton, Inc. Welfare Benefit Plan, a high deductible medical plan which is discussed in your Summary Plan Description;
- an HSA you establish; and
- health information, tools and support.

Benefits available under your medical plan are described in your medical plan Summary Plan Description (SPD).

**What is an HSA?**
An HSA is a tax-advantaged account Participants can use to pay for qualified health expenses they or their eligible dependents incur, while covered under a high deductible medical plan. HSA contributions:

- accumulate over time with interest or investment earnings;
- are portable after employment; and
- can be used to pay for qualified health expenses tax-free or for non-health expenses on a taxable basis.

## Who Is Eligible And How To Enroll

Eligibility to participate in the Health Savings Account is described in the SPD for your high deductible medical plan. You must be covered under a high deductible medical plan in order to participate in the HSA. In addition, you:

- must not be covered by any high deductible medical plan considered non-qualified by the IRS. (This does not include coverage under an ancillary plan such as vision or dental, or any other permitted insurance as defined by the IRS.)
- must not participate in a full health care Flexible Spending Account (FSA);
- must not be entitled to Benefits under Medicare (i.e., enrolled in Medicare); and
- must not be claimed as a dependent on another person's tax return.

## Contributions

Contributions to your HSA can be made by you, by your employer or by any other individual. All funds placed into your HSA are owned and controlled by you, subject to any reasonable administrative restrictions imposed by the trustee.

Contributions can be made to your HSA beginning on the first day of the month you are enrolled in the Health Savings Account until the earlier of (i) the date on which you file taxes for that year; or (ii) the date on which the contributions reach the contribution maximum.

Note that if coverage under a qualified high deductible health plan terminates, no further contributions may be made to the HSA.

The contribution maximum is the single and family limits set by federal regulations. Individuals between the ages of 55 and Medicare entitlement age may contribute additional funds monthly to their HSA up to the maximum allowed by federal regulations. The maximum limits set by federal regulations may be found on the IRS website at www.irs.gov.

If you enroll in your HSA within the year (not on January 1) you will still be allowed to contribute the maximum amount set by federal regulations. However, you must remain enrolled in a high deductible health plan and HSA until the end of the 12th month from your initial enrollment or you will be subject to tax implications and an additional tax of 10%.

*Note*: Amounts that exceed the contribution maximum are not tax-deductible and will be subject to an excise tax unless withdrawn as an "excess contribution" prior to April 15th of the following year.

## Reimbursable Expenses

The funds in your HSA will be available to help you pay your or your eligible dependents' out-of-pocket costs under the medical plan, including Annual Deductibles and Coinsurance. You may also use your HSA funds to pay for medical care that is not covered under the medical plan design but is considered a deductible medical expense for federal income tax purposes under Section 213(d) of the Internal Revenue Code of 1986, as amended from time to time. Such expenses are "qualified health expenses". Please see the description of *Additional Medical Expense Coverage Available With Your Health Savings Account* below, for additional information. HSA funds used for such purposes are not subject to income or excise taxes.

"Qualified health expenses" only include the medical expenses of you and your eligible dependents, meaning your spouse and any other family members whom you are allowed to file as dependents on your federal tax return, as defined in Section 152 of the Internal Revenue Code of 1986, as amended from time to time.

HSA funds may also be used to pay for non-qualified health expenses but will generally be subject to income tax and a 20% additional tax unless an exception applies (i.e., your death, your disability, or your attainment of age 65).

## Additional Medical Expense Coverage Available with Your Health Savings Account

A complete description of, and a definitive and current list of what constitutes eligible medical expenses, is available in IRS Publication 502 which is available from any regional IRS office or IRS website.

If you receive any additional medical services and you have funds in your HSA, you may use the funds in your HSA to pay for the medical expenses. If you choose not to use your HSA funds to pay for any Section 213(d) expenses that are not Covered Health Services, you will still be required to pay the provider for services.

The monies paid for these additional medical expenses will not count toward your Annual Deductible or Out-of-Pocket Maximum.

### Using the HSA for Non-Qualified Expenses

You have the option of using funds in your HSA to pay for non-qualified health expenses. A non-qualified health expense is generally one which is not a deductible medical expense under Section 213(d) of the Internal Revenue Code of 1986. Any funds used from your HSA to pay for non-qualified expenses will be subject to income tax and a 20% additional tax unless an exception applies (i.e., your death, your disability, or your attainment of age 65).

In general, you may not use your HSA to pay for other health insurance without incurring a tax. You may use your HSA to pay for COBRA premiums and Medicare premiums.

### Rollover Feature

If you do not use all of the funds in your HSA during the calendar year, the balance remaining in your HSA will roll-over. If your employment terminates for any reason, the funds in your HSA will continue to be owned and controlled by you, whether or not you elect COBRA coverage for the accompanying high deductible health plan, as described in your medical plan SPD.

If you choose to transfer the HSA funds from one account to another eligible account, you must do so within 60 days from the date that HSA funds are distributed to you to avoid paying taxes on the funds. If you elect COBRA, the HSA funds will be available to assist you in paying your out-of-pocket costs under the medical plan and COBRA premiums while COBRA coverage is in effect.

**Important**
Be sure to keep your receipts and medical records. If these records verify that you paid qualified health expenses using your HSA, you can deduct these expenses from your taxable income when filing your tax return. However, if you cannot demonstrate that you used your HSA to pay qualified health expenses, you may need to report the distribution as taxable income on your tax return. Lockton, Inc. and UnitedHealthcare will not verify that distributions from your HSA are for qualified health expenses. Consult your tax advisor to determine how your HSA affects your unique tax situation.

The IRS may request receipts during a tax audit. Lockton, Inc. and the Claims Administrator are not responsible or liable for the misuse by Participants of HSA funds by, or for the use by Participants of HSA funds for non-qualified health expenses.

## Additional Information About the HSA

It is important for you to know the amount in your HSA account prior to withdrawing funds. You should not withdraw funds that will exceed the available balance.

Upon request from a health care professional, UnitedHealthcare and/or the financial institution holding your HSA funds may provide the health care professional with information regarding the balance in your HSA. At no time will UnitedHealthcare provide the actual dollar amount in your HSA, but they may confirm that there are funds sufficient to cover an obligation owed by you to that health care professional. If you do not want this information disclosed, you must notify the Claims Administrator and the financial institution in writing.

You can obtain additional information on your HSA can be obtained online at www.irs.gov. You may also contact your tax advisor. Please note that additional rules may apply to a Dependent's intent to opening an HSA.

# ADDENDUM A - UNITEDHEALTH ALLIES

## Introduction

This Addendum to the Summary Plan Description provides discounts for select non-Covered Health Services from Physicians and health care professionals.

When the words "you" and "your" are used the Plan is referring to people who are Covered Persons as the term is defined in the Summary Plan Description (SPD). See Section 14, *Glossary* in the SPD.

***Important***:
UnitedHealth Allies is not a health insurance plan. You are responsible for the full cost of any services purchased, minus the applicable discount. Always use your health insurance plan for Covered Health Services described in the Summary Plan Description (see Section 5, *Plan Highlights*) when a benefit is available.

## What is UnitedHealth Allies?

UnitedHealth Allies is a health value program that offers savings on certain products and services that are not Covered Health Services under your health plan.

Because this is not a health insurance plan, you are not required to receive a referral or submit any claim forms.

Discounts through UnitedHealth Allies are available to you and your Dependents as defined in the Summary Plan Description in Section 14, *Glossary*.

## Selecting a Discounted Product or Service

A list of available discounted products or services can be viewed online at **www.healthallies.com** or by calling the number on the back of your ID card.

After selecting a health care professional and product or service, reserve the preferred rate and print the rate confirmation letter. If you have reserved a product or service with a customer service representative, the rate confirmation letter will be faxed or mailed to you.

***Important***:
You must present the rate confirmation at the time of receiving the product or service in order to receive the discount.

## Visiting Your Selected Health Care Professional

After reserving a preferred rate, make an appointment directly with the health care professional. Your appointment must be within ninety (90) days of the date on your rate confirmation letter.

Present the rate confirmation and your ID card at the time you receive the service. You will be required to pay the preferred rate directly to the health care professional at the time the service is received.

## Additional UnitedHealth Allies Information

Additional information on the UnitedHealth Allies program can be obtained online at **www.healthallies.com** or by calling the toll-free phone number on the back of your ID card.

# ADDENDUM B - ADDITIONAL ELIGIBILITY PROVISIONS

## 1. *Rules for Employees Reasonably Expected to Work an Average of 25, 30, or 37.5 Hours Per Week*

If it is reasonably expected as of your first day of work with the Employer that you will be employed on average at least 25 hours of service per week (and you are not a "Seasonal Employee" described below), you will become eligible under the Plan as of your first day of work in accordance with the following status levels:

- If you are a Participant who is employed an average of at least 37.5 hours or more per week, you can enroll yourself and any of your eligible Dependents;
- If you are a Participant who is employed an average of at least 30 hours per week, you can enroll yourself and your eligible Dependent children;
- If you are a Participant who is employed an average of at least 25 hours per week, you can enroll yourself but your Dependents are not eligible to participate.

Assuming you timely enroll for coverage upon becoming eligible, you will remain covered under the Plan at the relevant coverage level until at least December 31 of the year following the year in which you started working for the Employer, unless (i) you are a Part-time Employee who qualifies for a higher level of coverage at the end of the Initial Measurement Period described in section (2) below or (ii) you experience an event described in Section 12, *When Coverage Ends,* in which case your coverage will terminate in accordance with that section.

Once you have been employed for one "Standard Measurement Period," it will be determined annually whether you worked an average of at least 25 hours of service per week (or 30 hours or 37.5 hours for applicable Dependent coverage) during the applicable Standard Measurement Period. The Standard Measurement Period is the twelve (12) consecutive month period running from November 1 of one year to October 31 of the following year. If it is determined that you worked an average of 25 hours of service per week (or 30 hours or 37.5 hours for applicable Dependent coverage) during the Standard Measurement Period you will have an opportunity during Open Enrollment to continue coverage at the relevant coverage level, or to enroll for coverage if you are not enrolled under the Plan, for the following Plan Year. If you enroll for coverage during Open Enrollment, you will remain covered at the relevant coverage level under the Plan for the entire Plan Year (beginning January 1 following Open Enrollment) regardless of the number of hours you work during that Plan Year. If, however, you experience an event described in Section 12, *When Coverage Ends*, your coverage will terminate. If it is determined that you did not work an average of at least 25 hours of service per week (or 30 hours or 37.5 hours for applicable Dependent coverage) during a Standard Measurement Period, you will not be eligible for coverage during the following Plan Year (or you will be eligible for a different coverage level, depending on your average hours worked). This means your coverage will end on December 31 of the year in which it is determined you no longer worked an average of 25 hours of service per week (or 30 hours or 37.5 hours for applicable Dependent coverage). Regardless of whether you are covered under the Plan for a particular Plan Year, a new determination will be made each year of whether you worked on average at least 25

hours of service per week (or 30 hours or 37.5 hours for applicable Dependent coverage) during the Standard Measurement Period.

### *2. Rules for Seasonal, Variable Hour, or Part-time Employees*

You are a Seasonal Employee if you work in a position for which the customary annual employment is six (6) months or less. You are a Variable Hour Employee if the Employer cannot determine (at your date of hire) whether you are reasonably expected to work on average at least 30 hours of service per week because your hours are variable or otherwise uncertain. You are a Part-time Employee if the Employer (as of your date of hire) reasonably expects you to be employed on average less than 30 hours of service per week during the "Initial Measurement Period" explained below.

If you are a Seasonal Employee, Variable Hour Employee, or Part-time Employee you will not be eligible for coverage when you start work with the Employer (except that a Part-time Employee reasonably expected to work at least 25 hours of service per week is eligible to participate in the Plan as of his/her date of hire as described in section (1) above, but is not permitted to enroll Dependent children at such time). Instead, you will later be eligible for coverage under the Plan if it is determined that you worked on average at least 25 hours of service with the Employer (or 30 hours or 37.5 hours for applicable Dependent coverage) during the "Initial Measurement Period". The Initial Measurement Period is a period of twelve (12) consecutive months, beginning on your first day of work with the Employer. If it is determined that you worked on average at least 25 hours of service per week (or 30 hours or 37.5 hours for applicable Dependent coverage) during the Initial Measurement Period, you will become eligible under the Plan 25 days after the last day of the Initial Measurement Period. Your coverage will be effective as of such 25th day if Human Resources timely receives your properly completed enrollment. If you enroll in coverage upon becoming eligible, you will remain covered under the Plan at the relevant coverage level for the entire "Stability Period" (twelve (12) consecutive months, beginning on the first day you are eligible for coverage under the Plan), regardless of the number of hours you work during the Stability Period. If, however, you experience an event described in Section 12, *When Coverage Ends*, your coverage will terminate in accordance with that Section. You coverage may be continued during the next Plan Year (meaning during the Plan Year that started at some point during the Stability Period) if it is determined that you worked on average at least 25 hours of service per week for the Employer (or 30 hours or 37.5 hours for applicable Dependent coverage) during a "Standard Measurement Period" as described below. If it is determined that you did not work on average at least 25 hours of service per week (or 30 hours or 37.5 hours for applicable Dependent coverage) during the Initial Measurement Period, you will not be eligible under the Plan (or you will be eligible for a different coverage level, depending on your average hours worked) unless and until it is determined that you worked on average at least 25 hours of service per week (or 30 hours or 37.5 hours for applicable Dependent coverage) for the Employer during a Standard Measurement Period, in which case you will be eligible to enroll in coverage for the Plan Year that follows.

Once you have been employed by the Employer for one "Standard Measurement Period" (meaning the twelve (12) consecutive month period running from November 1 of one year to October 31 of the following year), it will be determined annually whether you worked an average of at least 25 hours of service per week (or 30 hours or 37.5 hours for applicable

Dependent coverage) during the Standard Measurement Period. If it is determined that you worked on average at least 25 hours of service per week (or 30 hours or 37.5 hours for applicable Dependent coverage) during the Standard Measurement Period, you will have an opportunity during Open Enrollment to continue coverage, or to enroll for coverage if you are not yet enrolled under the Plan, for the following Plan Year. If you enroll for coverage under the Plan, or elect to continue coverage, during Open Enrollment, you will remain covered under the Plan at the relevant coverage level for the entire Plan Year (beginning January 1 following Open Enrollment) regardless of the number of hours you work during that Plan Year. If, however, you experience an event described in Section 12, *When Coverage Ends*, your coverage will terminate in accordance with that Section. If it is determined that you did not work an average of at least 25 hours of service per week (or 30 hours or 37.5 hours for applicable Dependent coverage) during a subsequent Standard Measurement Period, you will not be eligible for coverage during the following Plan Year (or you will be eligible for a different coverage level, depending on your average hours worked). This means your coverage will end on December 31 of the year in which it is determined that you no longer worked an average of at least 25 hours of service per week (or 30 hours or 37.5 hours for applicable Dependent coverage). Regardless of whether you are covered under the Plan for a particular Plan Year, a new determination will be made each year of whether you worked on average at least 25 hours of service per week (or 30 hours or 37.5 hours for applicable Dependent coverage) during the Standard Measurement Period.

### *3. Hours of Service*

As explained above, the determination of whether you are eligible for coverage under this Addendum B depends on whether you are employed an average of at least 25, 30, or 37.5 "hours of service" per week with the Employer.

For this purpose, the term "hours of service" generally means each hour for which you are paid, or entitled to payment, for the performance of duties for the Employer; and each hour for which you are paid, or entitled to payment by the Employer for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty, or leave of absence. The definition of hours of service under the Plan will comply with the requirements under 26 C.F.R. §§ 54.4980H-1(a)(24) and 54.4980H-3.

For hourly employees, the Employer will calculate actual hours of service from records of hours worked and hours for which payment is made or due.

For salaried employees, the Employer will calculate hours of service by using a weeks-worked equivalency where the employee is credited with 40 hours of service for each week for which the employee would be required to be credited with at least one hour of service under the "hours of service" rules described above.

### *4. Change in Employment Status*

If you are a new Variable Hour Employee, Seasonal Employee, or Part-time Employee (as those terms are defined above) and you experience a change in employment status before the end of the Initial Measurement Period (as defined above) such that if you had begun employment in the new position or status you would have been reasonably expected to be employed on average at least 25 hours of service per week (or 30 hours or 37.5 hours for

applicable Dependent coverage) (or would have not been a Seasonal Employee and would have been expected to be employed on average at least 25 hours of service per week (or 30 hours or 37.5 hours for applicable Dependent coverage)), you will be eligible for coverage as of the first day of your new position or status. Assuming you timely enroll for coverage upon becoming eligible, you will remain covered under the Plan until at least December 31 of the year following the year in which you started working for the Employer (not the date you experienced a change in employment status), unless (i) you are still a Part-time Employee who qualifies for a higher level of coverage at the end of the Initial Measurement Period described in section (2) above, or (ii) you experience an event described in Section 12, *When Coverage Ends*, in which case your coverage will terminate in accordance with that section. Once you have been employed for one Standard Measurement Period, the rules described above in section (1) of this Addendum B will apply.

### *5. Rehired Employees*

(a) Rehired After 13 Weeks or More. If you terminate employment with the Employer and you are rehired by the Employer on a date that is at least 13 consecutive weeks after your termination of employment, you will be treated as a new Employee upon your rehire date for purposes of Plan eligibility.

(b) Rehired After Less Than 13 Weeks. If you terminate employment with the Employer and you are rehired by your Employer on a date that is less than 13 weeks after your termination of employment, you will be treated as a "continuing Employee" for purposes of Plan eligibility. In that case, if you were eligible for coverage immediately before your termination of employment, you will be eligible for coverage as of the date you resume work with the Employer. If you timely enroll in coverage, you will be covered under the Plan for the remainder of the applicable Plan Year (or Stability Period, if applicable). If, however, you experience an event described in Section 12, When Coverage Ends, your coverage will terminate in accordance with that section. Whether you will be eligible for coverage after the end of the applicable Plan Year (or Stability Period, if applicable) will be determined based on the Standard Measurement Period rules described in sections (1) and (2) of this Addendum B.

If you were not yet eligible for coverage immediately before you lost coverage due to your termination of employment, you will remain ineligible under the Plan (when you return to work for the Employer) at least until the end of the first Standard Measurement Period (or Initial Measurement Period, if applicable) after you are rehired. Whether you will be eligible for coverage after the end of that Standard Measurement Period (or Initial Measurement Period, if applicable) will be determined based on the Standard Measurement Period rules described above. Notwithstanding the provisions of this paragraph, if you are rehired as an Employee who is reasonably expected to work 25, 30, or 37.5 hours per week as of your first day of work, you will be eligible to enroll as of your date of hire as described under *Eligibility* in Section 2, *Introduction*, and section (1) of this Addendum B.

If your initial termination of employment was due to retirement, upon being rehired you will be covered under the Plan as an employee and not as a retired Participant.

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